The University of Alberta

Perceptions of Health & Use of Health Services: An Exploratory Study with Older Adults

by

Patricia Diane Leggett

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ABSTRACT

With the continuing increase in the aging population, health service planning for older adults has become more of a priority, to ensure that services are in place to meet the growing needs. This qualitative study used semi-structured interviews to explore the thoughts and opinions of older adults age 60 to 75, regarding their perceptions of health, their use of health services, and the factors that influence this use. Content analysis was employed.

This group of individuals considered themselves quite healthy, and included multiple components in their description of their health status. There was a strong proactive nature to their use of and opinions on health services. Five factors emerged as influencing service use: need, relationships with health professionals, feelings of personal control, availability of services, and quality of services. The findings from this study have implications for health planning, and are a good start for continued research in this area.

This thesis is dedicated to

Scott

My partner in love and life

May we grow older

Healthy

Happy and

Together

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CHAPTER I:

INTRODUCTION

There has been increased interest, in both the service provision and research communities, in the health status and health problems of older adults, and the interventions, services, and policies designed to address them. This study focused on how older adults perceived their health status, what services they used to respond to health problems and to maintain their health, and the factors that influenced this use.

The population is aging. The percentage of the population over the age of sixty-five is growing. The percentage of those over sixty-five years of age in Canada grew from 7.6% in 1961 to 11.6% in 1991, and some forecast that by the year 2041 over 22% of the population will be over the age of sixty-five (Rosenberg & Moore, 1997; Statistics Canada, 1997; Ulysse, 1997). The fastest growing category within this group is that of people over the age of eighty-five. In 1995, 58% of those over the age of sixty-five were women, increasing to 85% for those over eighty-five. Mortality rates for seniors have decreased, and life expectancy has increased. Their periods of poor health, however, are expected to continue to increase (Ulysse, 1997).

In 1991 more than 90% of those 65-74 years of age in Canada were living in the community, increasing to 95% in Alberta (Rosenberg & Moore, 1997). In 1995, 78% of adults age 65-74 and living in the community reported having at least one chronic illness, and about one-third of those that age had a health problem that restricted their activities (Rosenberg & Moore, 1997; Statistics Canada, 1997). Seemingly contradictory evidence however, shows that many older adults perceive their health as excellent or

good. These have also been multiple components identified within perceptions of health, in addition to physical health status. To understand this multidimensionality, it was important to describe the components of perceived health for this group of young older adults, to compare these findings to those found in the literature for older adults in general.

Though life expectancy is increasing, there is a changing pattern of illness and causes of death and disability among older adults, toward chronic and degenerative diseases. The progression is often slow, requiring an increasing need for social and health support services (Ulysse, 1997). These conditions can also lead to a decrease in the individual's autonomy, and an increase in their dependence on family and the health system. One can speculate then, that the aging population will increase in need for formal support services to assist in maintaining their health and independence, while at the same time preserving personal control over their lives. What needed to be explored further, however, were the health services older adults used, and the factors affecting this use.

Statistically, older adults use more health services per person, than younger individuals. Men and women over age 65 as a group, receive about 19 services per year in the Capital Health region, compared to 7.5 and 13 for men and women respectively, age 15-64 (Capital Health, 1997). Though many recognize that the age group of 65+ is very heterogeneous, it is still often used when discussing health, health problems, and health service use. These demographic and service utilization patterns have created some concerns about the impact of the aging population.

Some people believe that as individuals get older, they visit a doctor or health professional 'too' often – when they do not require medical care- and that the health care system will be over-taxed by this pattern of utilization. Some also believe that the majority of older adults are in poor health, and 'want' to be taken care of by the health system and society. Many older adults, however, are in good health and actively maintain their health. An accurate portrayal of older adults regarding their health problems, the services they use, and the factors that affect this use, was important. Thoughtful planning is also required, to address the health needs of older adults, now and in the future. An important step in this planning was an exploration of older adults' perceptions of their health and their use of health services.

Purpose of the study

This exploratory study described a small sample's perceptions of health and the components within, their use of health services, and the factors that influenced their use of health services. The purpose was to gain a better understanding of the components or aspects of their perceived health status and the factors that underlie their use of health services for this particular group, and whether they were similar or different than those shown so far in the literature. This study attempted to address both of these topics, as well as, to obtain information on the types of health services, and sources of health information they would use and the reasons why they would or would not use certain services. Its aim was to be a small step in the future planning of health services aimed at an aging population.

For this study *'health services'* included traditional medical care services and proactive health interventions (eg. nutrition counseling and home visits), either currently or

potentially offered within the health care system. Continuing care services were included, if mentioned, but were not addressed directly in the questions. Alternative health care providers were also included. '*Use*' included choices made regarding types of services, specific professionals, and methods of service provision.

This study was also undertaken partly to provide some background for a large study looking at the development of a risk identification system using administrative databases to identify older adults at risk for falls. The hypothetical computerized health record management system described in this study was designed to explore a few areas that may appear in such a system, to elicit the participants' opinions on them. The information gleaned in this study may be considered in the development of such a risk identification system.

Rationale for the study

Perceptions of health status may be comprised of many components, varying across individuals. Continued investigation of these components provided further support for the concept of multidimensionality of perceptions of health, and started to identify recurring components across studies. There may also be multiple factors that influence older adults' use of services, such as severity of illness, and past experiences with health services, that needed to be explored further. Continued research will provide support for this area of study, and better understanding of the variety and influence of factors that influence older adults use of health services. Those working in the health system will need to address not only the health and medical needs of older adults, but also their preferences for service provision.

The rationale for selecting this age range of 60-75 was twofold. First, there had been a growing amount of research targeted to individuals over the age of 75, as well as, to the 'baby boomers', who just reached the age of 50 in the past few years. The in-between age group (60-75) had been less apt to be the target of a research study, and may have varied from those older and younger than themselves in ways important to know when planning health services. For example, differences may occur related to their perceptions of health, the types of services they would use, and the factors that might influence this use. Second, these individuals are in a group that may make considerable use of health services in the future; therefore, health services planning for older adults will be targeted to this group.

There had been quantitative research on health perceptions and use of health services (Capital Health, 1997; Statistics Canada, 1997; Ulysse, 1997), using mostly rating scale types of questions only. Past research had also done a thorough job in illustrating the statistics of service utilization. The current study was a qualitative study using a semi-structured interview format to answer the how and the why behind the perception ratings and the utilization statistics. It explored the perceptions of the participants' own health, the types of health services they did and would use, and the factors that influenced this use. The close-ended questions were included to gather information on specific sets of the types of services used, sources of health information, and personal health problems. Closed-ended questions were also used to obtain ratings on perceived health status, and the quality and availability of services.

The majority of questions were open-ended, enabling the participants to expand on their answers, and encouraging them to share their opinions, beliefs, and experiences

regarding their use of certain services, the health care system overall, and their preferences regarding service provision. A qualitative approach lent itself to the richer descriptions of the perceptions and experiences sought in this study.

This study was approved by The University of Alberta Health Sciences Faculties, Capital Health Authority, and Caritas Health Group, Health Research Ethics Board (B:Health Research), in August 1999. See Appendix A for copy of the ethics approval form.

Objectives of the study

The objectives of the study were:

- to understand the components of perceived health status of these older adults
- to explore their use of health services
- to understand the factors that influence their use of health services

Research questions

- *How do older adults perceive their health status?*
- *What health services do and would older adults use?*
  - What sources of health information do older adults use?
- *What factors influence older adults' use of certain health services?*

CHAPTER II:

LITERATURE REVIEW

Introduction

There is an emerging cohort of older adults who are more educated, healthier, wealthier, and have a better understanding of the role of health behaviours in health status (Padula, 1992). Many seniors participate in health promotion/disease prevention activities, treat disorders themselves first before seeking medical care, and manage their chronic illnesses on their own (Kart & Engler, 1995; Padula, 1992).

Perceived health status of older adults

In this section, the current statistics for older adults will first be described, and then there will be a more in-depth look at the literature related to the components of perceived health.

In the 1996-97 National Population Health Survey (NPHS), 42% of participants age 65-74 rated their health as excellent or very good, and an additional 38% as good (Federal/Provincial/Territorial Advisory Committee on Population Health [FPTACPH], 1999). Approximately 50% of Albertans over age 65 rated their health as excellent or good, and 22% of those over age 65 in the Capital Health region rated their current habits and lifestyle as 'very healthy', compared to 13% of those under age 65 (Capital Health, 1997; Sefton & Mummery, 1995). Most research on perceived health status has been comprised of these ratings only. Idler, Hudson & Leventhal (1999) suggested that perceptions of health are only useful as a measurement tool, if the reasoning behind the ratings is looked at in conjunction with the ratings and with concurrent measures of

objective health status. There is growing research showing that perceptions of health have multiple components beyond just physical health (Borawski, Kinney & Kahana, 1996; Hall, Epstein, & McNeil, 1989; Idler et al., 1999; Kaufman, 1996).

In some studies where ratings of perceived health were queried as a comparison to others their age (Dening et al., 1998; Menec, Chipperfield, & Perry, 1999; Sefton & Mummery, 1995), the majority of those perceived it as good or better than others. In other studies this comparison emerged as one of the components of the perceptions (Borawski et al., 1996; Idler et al., 1999). All of these above studies found that the majority of older adults perceived their health positively.

Positive perceptions of health have also been linked with a belief of personal control, as seen in the study by Menec et al. (1999). The more positively they rated their health, the more likely they would actively be involved in managing their health problems. They found that health perceptions were predictors for perceived control, and control-enhancing strategies. "People who perceive themselves as healthy feel more in control" (p.P91).

Though almost 50% of those over age 65 in the Capital Health region rated their health as good or excellent according to a 1997 Alberta Health survey, almost 40% of them had a chronic condition requiring regular health services (Capital Health, 1997). The findings on the impact of chronic health problems on perceived health are mixed. Though some people's perceived health status was negatively impacted by chronic health problems, studies have found that most of the individuals with slight to significant health problems perceived their health as good or very good (Borawski et al., 1996; Dening et al., 1998;

Idler et al., 1999). Poor perceived health has been associated with increased use of services, and poorer ratings of the health care system (Capital Health; Dening et al.).

The following studies looked more closely at what types of things might impact on or comprise one's perception of their health. Borawski et al. (1996) categorized the attributions of 'self definitions' of health for adults over the age of 73 into five global categories (in order of frequency): physical health focussed; attitudinal/behavioral; health transcendence (have problems but look past them); externally focussed; and nonreflective. They used only the first attribution mentioned by each participant, regardless of what followed. Each of these categories had more specific attributions within that were both positive and negative.

Though they found this variety of attributions, less than 20% of the participants gave responses in more than one category, and 4% were nonreflective - unable to provide explanations for their ratings. This indicates that many of their participants may still have thought of health as comprised of a single attribute. Almost 40% of the participants, however, attributed their health to non-physical factors. Their findings supported the concept of multidimensionality, and stated that "many older adults' health definitions transcend externally imposed or medically defined health criteria, and include both proactive beliefs and social contextual factors in their definitions" (Borawski et al., 1996, p.S167).

Idler et al. (1999) created six categories to describe the reasons for the ratings of health provided by their participants, ages 58-95 (in order of frequency): physical health, diagnoses, symptoms; psychological, spiritual, emotional; physical functioning; health

risk behaviors; social role activities beyond basic functioning; and social relationships. As in Borawski et al. (1996), this study also included participants into only one category, but the inclusion was into a category that the majority of the participants' reasons fell. Idler et al. found that these broadness in perceptions of health was associated with positive perceptions of health.

Kaufman (1996) used focus groups with adults ages 67-91 to evoke statements regarding the group members' personal perceptions of health. Five broad categories were created to describe the variety of statements. In order of prevalence, these categories are as follows: activity, attitude, basic functions, absence of medical attention, and medicine (taking medications). The first two categories, which included the ability to get out of the house, exercise and volunteer, and one's state of mind, and comparisons to others, overwhelmingly accounted for the majority of responses, including 54 of the 78 statements made. Health was found to be a relative term that had a meaning that changed over time.

Kaufman (1996) also suggested that health promotion programs that consider these perceptions of health in their planning would be more effective because the older adults would find it more relevant and meaningful, as it would be addressing aspects of their lives that they consider important for their health. This idea could be applied to the development of any program or service aimed at maintaining the health of older adults.

Hall et al. (1989) wanted to know the contributions of both psychosocial and physical health to ratings of health for patients over the age of 70 and their doctors. They used principal component analysis to examine various health status measures from standard

assessment tools previously used with the patients. From this analysis, they identified distinct sub-components of health: functional status, emotional status, physiologic status, social activity, and cognitive status. Patients' ratings of health were associated, in order of strength, with physiologic status, emotional status, and functional status, but not social activity or cognitive status. This study did not use the patients' own descriptions, but it still supports the multidimensionaity of perceived health.

Borawski et al. (1996), Idler et al. (1999), and Hall et al. (1989) found that though there are multiple components to perceptions of health, there is still a large focus on the physical or medical attributes. Kaufman (1996), however, found that ability to stay active and one's attitude were more important for her participants. Only Borawski et al. and Idler et al. mentioned the inclusion of both positive and negative aspects to their components of perceived health. They both also allowed the inclusion of each participant into one category only, to clarify the results of the analysis. Borawski et al. placed participants into the category they mentioned first, where Idler et al. placed a participant into the category that contained the majority of their reasons behind their perceptions of health. These studies used samples with a broader age range than the current study, so it is of interest to explore how the components of perceived health for a younger sample of older adults to compare with these findings.

Older adults' use of health services

There are numerous areas of literature related to the use of health services by older adults. This review will focus specifically on the patterns of use of traditional and alternative health providers. It will describe older adults' patterns regarding maintaining

their health and responding to illness, as well as, some new appraisal tools developed to assess health risks.

In 1995, 96% of individuals over the age of 65 and living in the community reported seeing at least one health care professional; 87% general practitioners, 48% eye specialists, and 38% dental professionals (Statistics Canada, 1997). In a 1996/97 survey, 95% of adults age 65-74 reported visiting a health professional at least once in the past 12 months, and of those, 74% saw a physician more than twice (FPTACPH, 1999).

Rosenberg & Moore found that of those over the age of 65, over 70% visited a doctor in their office, versus in a walk in clinic, emergency room, or other locations (1997). They also found that until the age of 75, the utilization patterns of physician services for older adults was similar to other adults in Canada. Capital Health (1997), however, found that almost 19% of all physician services provided in the Capital Health region were to those over age 65, though they comprised only 10% of the population. Only 4% of those ages 65-74 used alternative health care, with acupuncture and massage therapy being the most frequently used (FPTACPH, 1999).

There is growing evidence that older Canadians regularly use health services to maintain their health. 47% of Canadians age 65-74 reported having a flu vaccine in the past year, and 89% had their blood pressure checked (FPTACPH, 1999). 59% had a physical check-up, and 77% of these people reported having them annually or more frequently. Though only approximately 25% of these individuals were insured for eye and dental exams, 53% and 45% respectively had seen these professionals for a routine

exam in the last year (FPTACPH). Hurwicz (1995) found in the literature that regular visits to the doctor by the well elderly were common. In his study, some of the participants saw the doctor only for routine check-ups, and it "became part of this group's treatment repertoire" (p. 231).

Fox, Breuer, & Wright (1997) did a study involving adults over the age of 65 in a community-based health promotion program. Services such as nutritional assessments and physical check-ups were conducted by public health nurses, and then a collaborative approach between a nurse and client was used to develop a plan to modify risky behaviours, and decide upon referrals. More than half of all participants followed through on the recommendations to improve their health and prevent illness. Stoller, Kart & Portugal (1997) found older women practiced more health promotion than older men, but men were more likely to seek consultation sooner. Proactive identification and treatment of health problems have already been shown to benefit older individuals, physicians, and society in general (Breslow et al., 1998; Fox et al., 1997; Hay et al. 1998). In addition, Fox et al. found personalized assessment and counseling in a health promotion program, can increase the use of these proactive measures.

Most older adults use a mixed model of care, inclusive of care by themselves, family and formal health workers, occurring either simultaneously or sequentially (Berman & Iris, 1998; Dill, Brown, Ciambrone & Rakowski, 1995; McWilliam et al., 1997; Stoller, 1998). Patterns of responding to illness and health problems have been explored in various studies. Musil et al. (1998) explored self-reported health problems and actions, and found that 43% chose to seek care for some of their problems, though less frequently used overall than using self-care measures – addressing problems themselves. In

exploration of responses to symptoms, Stoller et al. (1997) found a continuum ranging from ignoring symptoms to self-care to professional consultation only. 30.7% contacted a health care professional either immediately (13%), or after trying other methods of treatment, such as self-care.

The concepts of screening and health risk appraisals for older adults are new in the literature, but are topics of growing interest. A Health Risk Appraisal for the Elderly (HRA-E) was created to identify specific factors in individuals that increase the risk of impairment, so that strategies can be developed and recommended, to minimize their impact (Breslow, 1997). Over 90% of those completing the questionnaire found it easy to understand, and were happy with the length. 70% of those who received an appraisal report on their health risks planned to follow recommendations in the report to improve their health.

The Identification of Seniors at Risk (ISAR), which is a screening tool done by self-report at an emergency room visit, has been developed. This study resulted in its validation for use as a quick screening mechanism in emergency rooms, to identify older adults at risk of serious health problems (McCusker et al., 1999). Anther risk screening tool, a self-report mail survey accompanied by a personal letter from the family doctor, was implemented to determine the risk of functional decline (Dalby et al. 1999). They believe that a factor in their high response rate was the accompanying letter from the person's family doctor, and found that a mail survey was an effective way to assess the functional status of 'at risk' seniors.

All of these types of appraisals have been born out of the need to maintain health during our extended lifespan, growing support for this type of maintenance, and the need for periodic health reviews to guide health behaviours (Breslow et al., 1997; Dalby et al., 1999; McCusker et al, 1999). None of these studies, however, focused on the opinions of older adults about these screening tools.

There are many statistics kept on the utilization patterns of traditional health services and a growing number of statistics on other types of health services such as alternative services, illustrating a fairly proactive approach to health care. There are an increasing number of risk assessment tools for older adults, which are in the initial stages of being tested and evaluated. Few of these studies, however, explored the utilization of services in-depth for a small sample, to discuss their reasons and beliefs behind their use, and their opinions on these services.

Factors influencing older adults' use of health services

Many factors have been seen in the literature to impact on the overall approach taken to maintain one's health, and specifically on the use of certain health services. These factors most commonly found in the literature as influencing the use of services by older adults will be described.

Types and rates of service use can differ depending on perception of severity. In a small qualitative study, participants were interviewed regarding the type of care they used to respond to symptoms, and for those considered 'common', often no assistance was used (Dill et al., 1995). A review of literature on self-care found that both the 'properties' of the symptoms (eg. the amount of pain caused), and whether they are believed to be

serious affect the use of formal health services (Stoller, 1998). In exploring beliefs about health, Berman & Iris (1998) found that the perceived severity of past or current illnesses influences the decision to access services. Kart & Engler (1995) stated that in addition to actual illness symptoms, the perception of the seriousness of these symptoms may affect whether people tend to the symptoms on their own, or seek medical assistance. Overall, after seeking care for specific symptoms, worry about severity of symptoms was the next most common reason to seek formal care (Hurwicz, 1995).

Whether older adults attribute a condition or illness to aging also affects their use of services. It was found in certain studies that service use was minimized for those conditions perceived as aging-related (Dill et al., 1995; Stoller, 1998). This was related to the belief of the study participants that there was nothing to be done for an illness or disability that was 'strictly' related to their age. Kart & Engler (1995) found that some participants grouped 'old age' as a cause of illness with other things they felt were out of the doctor's realm, and did not seek assistance for any of them.

Hurwicz (1995) conducted a study looking at the consistency of decisions between older adults and their doctors, regarding the necessity of visits to the doctor. He found that there was congruence between the two groups overall. He also found that those visits considered medically unnecessary by the doctor were often characterized by concern about the seriousness and the chance of deterioration on the part of the patient. Relief was gained through reassurance by the doctor there was nothing to worry about. Gravity of illness was one of the first things that the participants decided upon to assess whether to access services. Once determined not to be serious, if they did not have knowledge or experience with the illness, the participants sought assistance (Hurwicz).

The levels of faith in physicians, in the efficacy of the treatment, and the medical care system have been identified as affecting the use of services. 13% of those who sought treatment in the study by Hurwicz (1995) said that they had faith in their doctor's ability to cure them. One of the findings in a study on seeking or avoiding care, was that overall the participants had more faith in their own ability to assess their health than a doctor or medical machine (Koval & Dobie, 1996). Some of the literature reviewed by Padula (1992) linked the use of 'self-care' with various factors, one of which was the efficacy of physician care. Padula states, however, that much more research would need to be done in this area to substantiate some of these findings.

Ageism has been found to be pervasive in the health care system. For example, the age, gender, and care setting of the physician were found to impact on the quality of an encounter with a health professional from an older patient's perspective (Adelman, Green, & Charon, 1991). The prevalence of stereotypical beliefs appeared to vary according to these variables in their study. Only a small percentage of participants in other studies felt their doctors were either in a hurry, did not explain medical problems or discuss health issues, and that the doctor was 'doing them a favour' by talking with them (Koval & Dobie, 1996; Lee & Kasper, 1998). More informative, respectful, and supportive physician attitudes will enhance encounters between health professionals and older adults (Adelman et al.; Lee & Kasper).

Studies focusing on older patient's satisfaction with health care found strong positive responses regarding their doctors, and their overall care (Bene, Liston, Nelson, Devine, & Banerjee, 1998; Lee & Kasper, 1998; Owens & Batchelor, 1996). Satisfaction with care is key to studying health behaviours of older adults, as dissatisfaction has been

shown to be highly correlated with poorer medical regimen adherence, increased likelihood of delays in seeking future assistance, and poorer understanding and retention of medical information (Adelman et al., 1998; Bene et al.). In Fox et al.'s study described earlier, they found that when the health recommendations were provided in both written and verbal form versus verbal form only, more participants acted on these recommendations for health behaviour change (1997).

Bene et al. (1998) also found communication with medical staff was the lowest rated category in their study on older patients' satisfaction with health services. The doctors rarely provided information on maintaining health and avoiding illness. Communication for older adults can also be compromised by sensory, cognitive and mobility deficits (Adelman et al., 1991). Demographic characteristics of both patient and physician can affect communication (Haug, 1996). In addition, long-term relationships can be beneficial to both older patient and their doctor, in that both know what to expect from the other, or detrimental, if they are in such a routine that they make assumptions about the services being provided or received (Haug).

An early review by Dean (1989) found that locus of control and autonomy had not been linked with service use, but other research strongly links them (Berman & Iris, 1998; Davies, Laker, & Ellis, 1997; Dill et. al., 1995; Stoller, 1998; McWilliam et al., 1997). Dill et al. found a continuum of decisions ranging from those who cared for their symptoms almost entirely themselves with a repertoire of learned methods, to those who took no action regarding their health without the advice of a physician or nurse. In the study by Owens & Batchelor, many of the older patients felt that health decisions were only to be made by health professionals. Davies et al., however, emphasized the importance of

promoting autonomy and independence of older patients in improving the quality of the care being provided. Two of the key areas of literature they reviewed in their study were related to the inclusion of patients in care decisions, and avoiding communication in a controlling manner.

The concerns of access and cost are at the root of many health service choices. Most seniors need and/or want to keep their financial output minimized. Maintaining financial independence outweighed seeking medical care if a choice had to be made by the participants in the study by Koval & Dobie (1996). Transportation issues, time of the day, and program costs were all found to be common deterrents to participation in community health programs or access to services (Koval & Dobie, 1996; Linda Macleod & Associates, 1997; Padula, 1992; Whetstone & Reid, 1991). Hurwicz, however, found that neither cost nor long waits emerged in the six categories as reasons for seeking/not seeking treatment (1995). The cost finding, however, was likely due to the sample being comprised of Medicare recipients, whose medical costs were covered.

In addition, family support and cultural traditions have also been shown to have an impact on health service use. One's social network affected the use of services, as those with larger support networks tended to access formal services less frequently (Stoller et al., 1997). Dill et al. (1995) found that social networks, and especially relationships with children and spouses, clearly influenced response to illness. Those with strong relationships tended to care for themselves and each other, rather than seek treatment, unless quite serious. Culture can also affect one's decisions regarding health behaviours and service use, as what a person considers the best way to treat illnesses or injuries may come from their cultural environment (Berman & Iris, 1998; Dean, 1989).

Many characteristics of health supports and programs have been identified in the literature as being important to seniors. These included those promoting and respecting the decisions and independence of seniors; those that incorporated any special needs of seniors (ie. vision difficulties); those that provided an array of services to choose from; and those that were accessible (ie. financially, physically, and geographically). The National Framework on Aging (NFA), developed by the Federal/Provincial/Territorial Ministers Responsible for Seniors, identified five principles that all policies and services for older adults need to consider: dignity, independence, participation, fairness, and security (1998).

Summary

Though most older adults perceived themselves as fairly healthy, health can be perceived as more than one thing to one person. Even people with similar backgrounds, cultural or otherwise, may perceive their health using different combinations of components (Kaufman, 1996). The literature identified a number of components of perceptions of health for older adults over the age of 50. There was much recurrence in themes across these studies, in that physical health was only one of a number of components in these perceptions. There were no studies that look at a younger sub-group only, such as those 60-75, to see what components comprised their perceptions of health.

We seem to know a great deal about the utilization patterns for hospitals, doctors, and other health professionals, but there were mixed findings on those over the age of 65 in general and those in younger age subgroups. Exploration with a group of adults ages 60-75 will assist in confirming some of these patterns. There was also a lack of research on the reasons and experiences of these individuals regarding their use of services, and

on how people felt about proactive interventions designed by the health system to maintain or promote their health. Though this may be because this is a newer area of research and service provision, it now needs to be examined.

The literature on risk identification systems or health appraisals is increasing, and was focused on the feasibility of the different appraisal methods, and the validity of these systems in determining health risks. Two of the studies were focused on those already somewhat at risk (Dalby et al, 1999; McCusker et al., 1999). Though feedback on the questionnaires and health reports themselves were obtained in one study (Breslow et al., 1997), to date little research has been done on people's reactions and feelings about such a system.

The literature exploring the variety of factors that influence the use of services is growing in size and scope. Factors have been identified in many realms including physical, psychological, economic, and cultural. More researchers are exploring these topics through the words of the individuals themselves. Much of the current research is framed to compare the reasons for choosing self-care treatment versus formal health services. Also, the literature tended to examine one potential factor, such as satisfaction of services for a group of people, and the influences on use of services was an indirect finding. Studies exploring multiple factors for the same group of people is a missing piece of the puzzle.

There is clear evidence to show that older adults will be more responsive to health services that offer them tools to build on what they already know, and that consider their own perceptions of health (Berman & Iris, 1998; Kaufman, 1996).

CHAPTER III:

METHODS

This study was undertaken as a qualitative study with a small sample, to allow for in-depth exploration of the participants' perceptions of their own health, the types of health services they do and would use, and the factors that influence this use. It will complement the quantitative research in these areas by adding the thoughts and opinions of a group of older adults to enhance the 'numbers'.

Semi-structured interviews were used to collect the data. They combined structured and unstructured formats, using a question guide to ensure certain topics were covered (Fontana & Frey, 1994). In-person, semi-structured interviews allowed for flexibility in the time needed for completion, clarification of confusing questions, and expansion on details pertaining to certain questions.

Sample

The population from which the participants were identified consisted of community-dwelling, 'independent' adults between the ages of 60 and 75. The study included individuals living in their own house or apartment, or a seniors housing complex. These individuals could be receiving assistance either formally or informally. It did not include individuals living in a seniors lodge, or any level of continuing care facility. The focus of the study was on individuals without cognitive impairments. Through the collection of background information at the end of the interview, some physical, emotional, and cognitive health conditions were identified, and as with many studies, decisional capacity was assumed until otherwise indicated.

Potential participants were identified through personal contacts, and advertisements at seniors housing and seniors centres. Information posters were put up in five seniors centres and two residential complexes around Edmonton. See Appendix B for an example of the poster.

The researcher did not use names and contact numbers provided by others to contact potential participants. Individuals made aware of the study by participants or other individuals familiar with the study were responsible for initiating contact with the researcher. Once contacted, the researcher described the study, and discussed the tape recording and location of the interviews. Individuals wanting to continue were given the opportunity to receive the information letter and consent form ahead of time, or at the same time as the interview. Most participants chose to set the interview at the time of the initial telephone call. They received the information letter and consent form at the beginning of the interview process, and discussed the study in detail at that time. See Appendix C and D for the information letter and consent form.

All individuals who contacted the researcher chose to participate in the study. If two spouses wanted to participate, they were interviewed separately and privately. One non-participating spouse observed the interview process. The initial sample consisted of 15 individuals derived through a snowball sampling technique (Bernard, 1995; Morse & Field, 1995). People familiar with the study talked with people they knew, who might be interested in participation. After the first 15 participants, which had been pre-set as the minimum sample size, three more participants were included through purposive sampling to add two more participants in the upper age category, and one more male to increase the male participation. The final number of 18 was determined at the point

where the researcher was not hearing anything new, by the pre-set parameters of the study, and the attainment of a broad spectrum of participants.

Interviews

Development of interview guide

The semi-structured interview guide was based on the research questions. It was piloted with three older adults, for feedback on the length of the interview, the wording used, and their perceptions of the questions (Bernard, 1995; Seidman, 1998; Shi, 1997). This feedback was used to revise the interview guide. Feedback was also obtained from a group at a seniors centre, on the inclusion of the particular proactive interventions chosen for the interview guide.

The researcher and a committee member who has done extensive research in the field of gerontology reviewed the interview guide, and it was then used for the first two interviews. Afterwards, minor changes were made to the guide to clarify two questions, and this version was used for the remainder of the interviews. See Appendix E for the final version of the interview guide. The questions covered areas relating to the participants' perceptions of their health, their use of various health services, and their opinions regarding factors that may influence their use of services. Demographic questions and a listing of chronic conditions were also included. The guide incorporated aspects of some questions from the 1996-97 NPHS (Statistics Canada, 1997) to provide some standardization to the wording and lists used, and to allow for the potential comparison of the study and NPHS samples.

Interviewing

The semi-structured interviews ranged in length from one-half hour to three hours. Sixteen interviews occurred in the participants' homes, and two at the participants' workplace. The information letter and consent form were discussed and signed at the beginning of each session; as well, any additional questions regarding the study were addressed. The format of the interview was explained, including the participant's right to stop the process at any time, even after completion of the interview.

Each participant was queried at least once throughout the interview, about how they were feeling, if they wanted a break, and if they wanted to continue or stop. At the beginning of each interview, the participants were offered a slightly adapted copy of the interview guide to use to follow along if they so chose. All participants were informed that they might be contacted later in the study to discuss findings (member checking). They were also asked if they would be interested in receiving some information from the final thesis. All participants were interested, and will be contacted at the end of the study with a summary of the findings.

The primary researcher completed all of the face-to-face interviews. The sessions were audio-taped, and the interviewer also made brief field notes during each interview. Immediately following each interview, the audio recording was checked for sound quality, and additional field notes were written at this time. The taped interview was then listened to in its entirety and additional notes were taken to record initial impressions, before transcription of the tapes. A study diary was used to track structural and methodological decisions. The researcher also kept a journal of personal thoughts and

feelings, to identify potential bias, which assisted with maintaining as objective a view as possible (Rodger & Cowles, 1993).

Data Analysis

All data (including interview transcriptions, field notes, study diary, and personal journal) were included in the analysis. As a semi-structured format was used, data collection and analysis occurred sequentially not simultaneously (Morse & Field, 1995). Each interview was transcribed by a professional transcriber, and stored in hard copies and computer files. The researcher then completed a verbatim verification of each transcript, by reviewing the written document with the audio-taped interview. These became the verified, final transcripts for analysis. These data were analyzed through rigorous content analysis (Marshall & Rossman, 1995; Morse & Field, 1995; Rothe, 1994).

Manual methods were used at all levels of coding and data reduction, instead of computer software. Many copies of each transcript were used in the successive rounds of coding and categorizing, using colour markers. All iterations of the coding were documented and kept in a 'code folder' to ensure a systematic and replicable process. The manual methods employed by the researcher allowed for continual immersion in the data.

Content analysis by question topic area is commonly used with a semi-structured interview format, and was used during the initial coding and analysis phase (Morse & Field, 1995). The topic areas covered in the interview guide, as well as, broad topic areas that were mentioned by participants were used to guide the construction of these initial coding categories and subcategories.

After this initial category development, inter-coder reliability was performed with two colleagues to ensure the soundness of the initial category development. The Kappa coefficient results for the inter-coder reliability are shown in Appendix F. Kappa was equal to 1.0 for comparison of the researcher to both the coders, which indicates the initial coding scheme had high reliability. Though these Kappa scores may be indicative of a simplistic inter-coder reliability exercise, it still suggests that the initial coding scheme developed was replicable and made sense beyond the researcher's interpretation.

Content analysis continued with the data being cut from the transcripts and regrouped onto flip chart sheets according to the category codes, across the participants. This process was iterative with some categories that required further breakdown, and were then clustered according to aspects of the research questions. All frequency counts were completed, and graphed or charted using Excel software.

The demographic and health conditions data were collated into one of three age groups, 60-64, 65-69, or 70-74. Frequencies for the demographic data were calculated and charted for each age group. Frequencies for the health conditions data were tabulated by age group, and by health condition.

The data relating to perceptions of health were grouped onto a flip chart sheet and coded by their rating – excellent, very good, good, fair, poor. The frequency of each health rating was counted and graphed. Data were then labeled with a phrase describing the meaning or topic of the excerpt (Morse & Field, 1995), such as 'activity-based', 'freedom from major illnesses', 'not sick often' and 'relative to many'. These labels were

then gathered into groupings, which formed the 'components' of perceived health. The data were summarized according to the these 'components'.

The data related to the use of health services were analyzed in a similar manner. First the data were separated into categories by service or intervention type - traditional and alternative health service providers, proactive health intervention areas, and sources of health information - and then coded by the subcategories within each that were addressed in the interview. The subcategories included types of traditional and alternative health providers, and proactive health interventions such as receiving information, or having a home visit from a health professional to check for risks for falls.

Positive and negative responses were counted for each subcategory within each category and charted, describing whether participants do or would use that particular service or intervention. The data excerpts were then labeled with a term or phrase that described the meaning or topic, such as 'upon request'. Similar labels within each category, such as, 'self-initiated', were then grouped to form themes that underlay use of that service or intervention. The data were summarized by the service or intervention type, and the subcategories within each.

Some of the information about factors influencing the use of health services was elicited directly in the interviews, and some emerged solely from the participants' discussions of their use of and experiences with health services. Clustering and collapsing of these categories occurred by moving sticky notes with the categories written on them around on a flip chart sheet, to form groups of similar topics. The goal of this process was the formation of mutually exclusive thematic categories, or 'factors' found in this study to

influence use of health services. The researcher then labeled each factor, trying to use a phrase that captured the categories within. The involvement of the participants' personal experiences versus their perceptions of others' experiences in their opinions was also clarified as much as possible. The results addressing this final research question were then summarized according to each factor, and illustrated in a diagram. In addition, the factors of availability and quality of services were summarized in conjunction with the frequency results of the rating questions addressing these topics.

Emerging themes and patterns were compared with the data, the literature, and a theoretical model (Creswell, 1998; Morse & Field, 1995; Rothe, 1994). This assisted with evaluating the plausibility of the developing propositions regarding perceptions of health, the use of health services, and the potential influencing factors on service use. Verification of the findings also occurred through member checking, or taking the findings back to participants for feedback and opinions (Marshall & Rossman, 1995; Miles & Huberman, 1994; Morse & Field, 1995). Member checking was performed with four study participants after the findings were summarized. The key findings for each research question were presented, and the participants commented on each of them, and the study topics in general.

Rigor

In qualitative research, the concepts of reliability and validity are supported differently than in quantitative research. In this study, rigor was addressed through neutrality, truth value, and reliability (Appleton, 1995; Miles & Huberman, 1994; Rothe, 1991).

Audio-taping the interviews enhanced the reliability and neutrality of the data. As the tapes were transcribed word for word, the analysis was not strictly based on the written recording and interpretation of the interviewer (Fontana & Frey, 1994; Marshall & Rossman, 1995; Seidman, 1998). Member checking was also utilized in this study, to ensure the maintenance of the 'truth value' - that the findings faithfully reflect the experiences of the older adults in this sample.

The use of a study diary and other documentation procedures to track structural and methodological decisions strengthened the reliability by creating a transparent audit trail (Miles & Huberman, 1994; Morse & Field, 1995; Shi, 1997). Two colleagues participated in an inter-coder reliability exercise, to test the consistency of the initial coding scheme. The Kappa coefficient was used to determine the inter-coder reliability (Pett, 1997). Data will be retained and is available for review by another researcher, under appropriate conditions. The findings were reflective of and valid for the study participants only, as generalizability was not a goal of this qualitative study (Marshall & Rossman, 1995). The use of a theoretical model and literature review, in which to compare the results of the study, added to the quality and validity of the findings.

Ethical Considerations

The researcher clearly explained the study processes, and the benefits and risks. The pace of the interview was set by the participants, and breaks occurred upon their suggestion (Bernard, 1995; Higgins, 1998; Kavanaugh & Ayres, 1998; Shi, 1997). All participants chose to answer every question. All participants appeared comfortable throughout the interview, and shared their opinions openly on the topics being discussed. General information on services in the Edmonton region for older adults was

offered to each participant at the end of the interview, to help increase the awareness of available services. Those who did not already have the information were interested in some or all of it.

There was the potential issue of informed consent, regarding cognitive capacity, but this issue never arose. Guidelines of who has access to the information were made clear to the participants verbally and in the information letter, and will be documented in all reported findings (Higgins, 1998; Kayser-Jones & Koenig, 1994). All participants were given the opportunity to discuss the study, information letter and consent form with the researcher, and were required to sign a consent form prior to participation. The data will be stored in a locked cabinet for a minimum of seven years, and access will be limited to that of the researcher. Neither participant names nor other identifying information will be used in any reports or presentations. If additional analysis is to be conducted, further ethics approval will first be sought.

Benefits & Risks

There were no direct, individual benefits for the participants resulting from this study, nor were there any individual risks to participants. The process and expectations of the requirements of the participants were discussed. This included such things as the time commitment needed, and the types of information that would be requested and discussed.

CHAPTER IV:

RESULTS

Description of sample

The sample for this study consisted of 18 individuals between the ages of 60 and 74. There were 12 female and 6 male participants. The characteristics of the sample can be seen below in Table 1.

Table 1: Description of Sample

Age category	*N =*	*Gender*		*Spouse*		*Employment status*	
		Female	male	yes	no	working	retired
60-64	6	3	3	5	1	4	2
65-69	7	5	2	6	1	0	7 (2*)
70-74	5	4	1	2	3	0	5 (1*)
Total	18	12	6	13	5	4	14

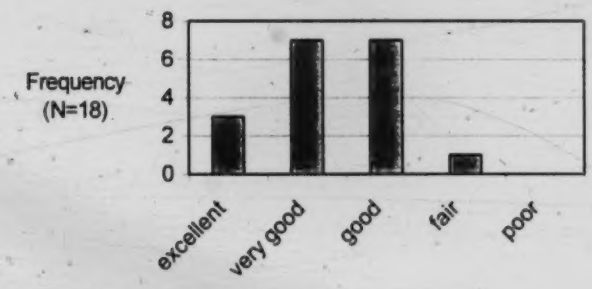
* working still on another business (eg. home business)

Thirteen of the participants were married, four were widowed or divorced, and one was never married. Four participants were still working, and the other 14 considered themselves retired, however, three were still working part-time (eg. home business). The participants had worked in a variety of professions before retirement including secretary, sales clerk, teacher, agrologist, accountant, nurse, and university professor. Though their occupational backgrounds were diverse, they indicated a fairly well educated sample.

How do older adults perceive their health status?

Participants were asked to rate their health, and then to describe what that rating meant to them. Comments made throughout the interviews related to perceptions of health were also coded and gathered with this question to explore these perceptions. The distribution of perceived health ratings can be seen in Figure 1. The participants considered themselves in fairly good health; over half rating it as 'very good' or 'excellent'.

Figure 1: Participants' Perceptions of Their Health



Both positive and negative aspects of their lives shaped their perceived health ratings. Eight categories encompassed the responses of participants when asked to describe these ratings, and are displayed in Table 2 as components of their perceived health. The following excerpts illustrate the multidimensionality of these ratings.

> "Well, as far as I know my heart is good. As far as I know, my head still works. I hear relatively well, but I have one ear that doesn't work as well as the other...I wear glasses but my eyes are good...I suffer from a little bit of arthritis which makes me creak a little bit...but...so relative to many, I'm good."
>
> "I'm [age], I don't have arthritis, I don't have problems walking or standing. I can do all of my own housework – cooking, cleaning. I try and help others. I look at the other ladies around me. They all think I'm a lot younger than I am! Which I feel is good."

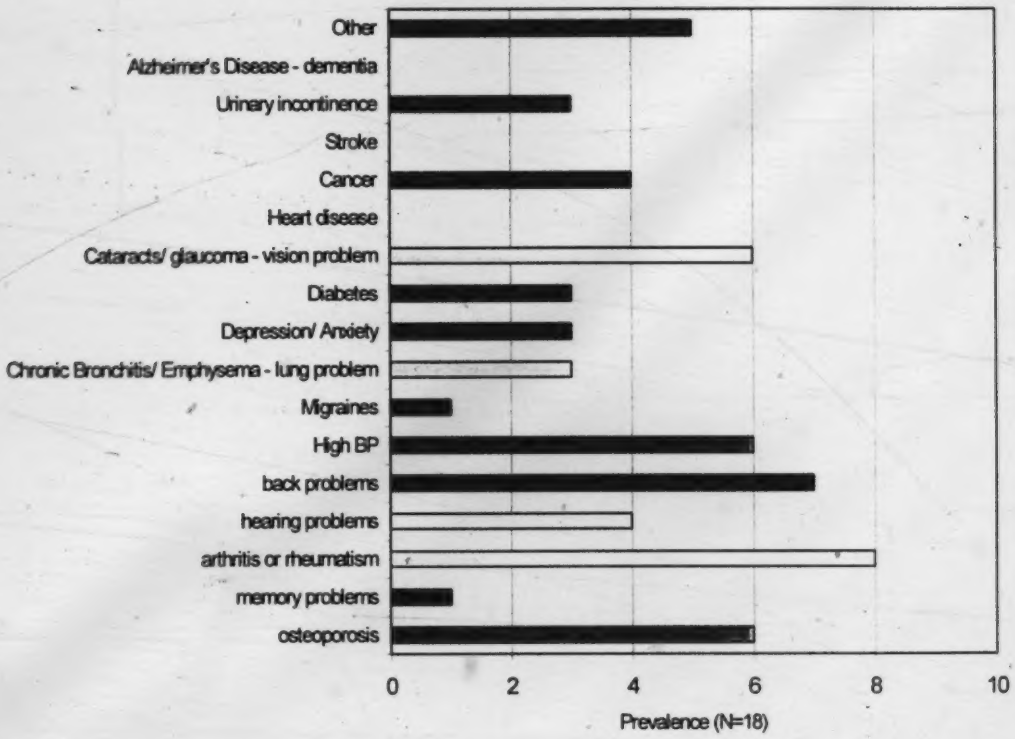
Table 2: Components of the Participants' Perceived Health	
Components	*Frequency*
Energy or activity levels	10
Physical health/Impact of health problems	10
Frequency of illness/ visits to the doctor	8
Attitude	8
Feeling of independence	6
Changes to lifestyle	3
Comparisons to others their age	3
Spirituality	2

Some felt that keeping healthy was really just commonsense, and that keeping active was the most important aspect of being healthy. Ten participants talked about energy and activity levels in their descriptions of their health ratings, most in the context of the importance of being involved in activities and keeping busy.

> "But I don't have much energy and I don't feel I can even walk very far without feeling huffy and puffy."
> "I have a lot of energy. I'm rarely sick and [long pause] I guess many people say that for my age of [age] that I don't look that way or act that way often."
> "I've been able to do a lot of things, whether it's travelling...I've been able to do outside physical work and all of that."

In regards to physical health/impact of health problems, participants shared information regarding health problems when describing their health. They were also asked whether they had been diagnosed with certain chronic conditions. There were a variety of health conditions reported by this sample. See Figure 2 for the prevalence of various conditions within the sample.

Figure 2: Types & Prevalence of Health Conditions for this Sample



All participants listed two or more chronic conditions, except one who listed only one condition. The average number of chronic conditions by age category was 2.83 (60-64), 3.57 (65-69), and 3.8 (70-74). Overall, the study participants were living with an average of 3.39 chronic health conditions. Only ten participants, however, mentioned the impact of these conditions in their perceptions of health. All three of the participants with more than five health conditions rated their health as good, and two of their descriptions of health follow.

"My back is in poor shape. My knees, arthritis is starting, but otherwise, we are living healthy, take our vitamins, eat healthy, you can see it, so I think that will be *good*. "

"They thought I had cancer, and I didn't, so my health is *good* now. When I say good, a lot of health problems is psychological too, and you can be in the best of health and still be sicker than a dog."

Frequency of illness/visits to the doctor was the next most common category used to describe perceived health, including comments from eight participants. This component includes how often or for how long someone might be ill, as well as, how often they need to go to a doctor for illness or other health problems.

"I do have a couple of ongoing conditions....As long as I'm on medication, I keep in touch with the doctor as well, things seem to go fairly well."
"--I don't have to go to the doctor, I don't take hardly no pills."

Eight participants also used descriptions that were placed into the attitude component. This component included comments about happiness, living healthy, and having a good life, or the lack of these things.

"...and I'm happy, independent"
"...we are living healthy, take our vitamins, eat healthy...you can see it"
"I have to get occupied, I can't just sit here and die."

Independence, which also included comments on mobility, was used by six participants in their descriptions of why they perceived their health at a certain rating. Though this included any statements related to independence, comments about one's functional ability to do things on their own were the main focus.

"Well, I'm getting around. I can see and I'm still driving, which is going to be a problem in time to come..."
"I don't have problems walking or standing. I do all my own housework - cooking, cleaning."

Less frequent categories used to describe health, included changes to lifestyle, comparison to others their age, and spirituality, or the importance of spiritual support or religion in their life.

"I don't think my health has deteriorated from the type of lifestyle that I enjoy having a whole lot."

"I guess not as many problems as many people our age have."

"I think a spirit of optimism is another one [way she describes her health], a spiritual outlook."

What health services do older adults use?

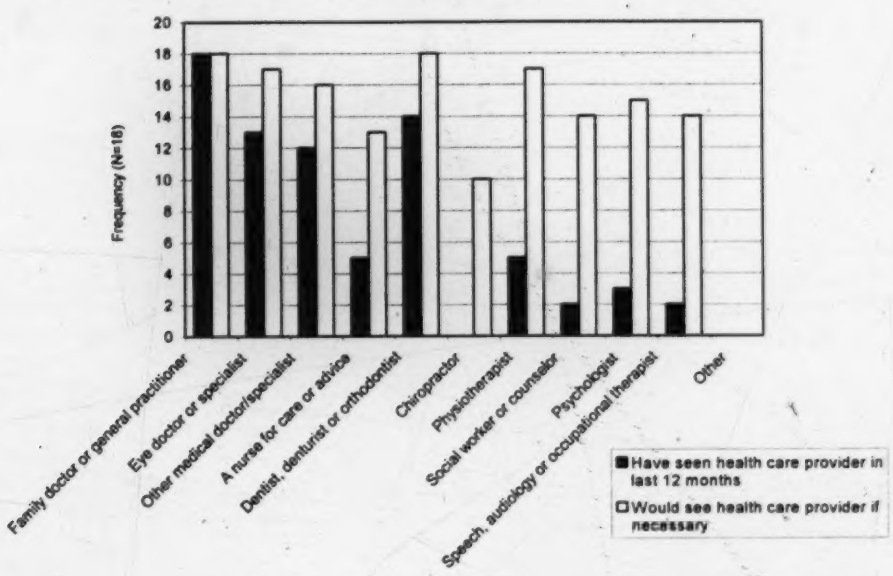
The researcher listed various health professionals, and asked participants whether they had seen or talked to each of them the last 12 months for their physical, emotional, or mental health. If they had not, they were asked if they would see that type of professional if the need arose. This was done to determine the types of professionals they *would* use. If they had used a health professional, they were also asked how often. This last question, however, was interpreted differently by participants, and therefore, some of the data were not comparable between participants.

Traditional health services

The use of traditional health professionals can be seen in Figure 3. All participants had seen a general practitioner or family doctor at least once in the past 12 months. Over two-thirds of the participants had seen professionals in the following three categories in the last 12 months: eye doctor/specialist, other medical doctor/specialist, and dentist/denturist/orthodontist. In addition, almost all participants stated that they would see all of the above professionals if the need arose. In order of descending frequency, the categories of nurse, physiotherapist, psychologist, social worker/counselor,

speech/audiology/occupational therapist and chiropractor were infrequently used in the past 12 months. No additional types of professionals were mentioned in the interviews.

Figure 3: Frequency of Use of Traditional Health Care Providers



When asked, however, whether they would use certain types of services if needed, the majority of participants again said 'yes' for most services. One exception was chiropractors, as only half of the participants said that they would use chiropractic services if they had such a need. Many of the negative comments regarding the use of chiropractors were personal beliefs about the service, and one participant mentioned cost as a potential determinant. Nine participants stated that they would use any of the services if there were a health need that should be addressed by that type of professional.

"You mean if the need was there? I think I'd feel free to go to any of them."

Five more participants stated that except for chiropractic services, they also would use any of the types of services. There were a number of participants who mentioned regular check-ups as part of their use of services; eight with a family doctor, nine with a dentist/denturist/orthodontist, and five with an optometrist or ophthalmologist.

Alternative health services

Only four participants had accessed an alternative health care provider in the last 12 months; all massage therapists. The other categories of acupuncturist, homeopath/naturopath, relaxation therapist, herbalist, and reflexologist, were not accessed, and no additional types of providers were mentioned. There was a more positive response when participants were asked whether they would access any of these services, if the need arose. At least half of the participants indicated that they would use, or at least explore massage therapy and relaxation therapy. The other types of services were each of interest to a few participants. Four of the participants stated that they would use any of the types of services, and seven initially stated that they would not choose to use any of them.

> "I have no prejudice one way or another. If I thought any one of them would help, if there was an issue, no hesitation."
>
> "Well...I think I would generally tend towards the more traditional kinds of health care...I might, in fact, avoid most of those"

Four of the latter group qualified their choices; two said that they would possibly try an alternative health care provider if recommended by their doctor, and two said that their opinions might change if faced with a serious illness or disease.

> "I don't think I'd use any of them, unless it was recommended by my doctor. I wouldn't go looking for any of them."

"Who knows, if you had some dreadful disease you'd try anything."

There was also some mention of reading about or trying various herbal medicines and therapies, but independent of a health care provider.

Proactive health interventions

Proactive services in the areas of nutrition, community health clinics, falls, medications and driving safety had been identified through research and discussions as potentially pertinent to older adults, and were explored in this study. Participants were asked if they would find each useful now and in the future. A health records management system, designed to assist in the identification of potential health risks was described to them, and they were asked their opinions about various aspects of such a system. Responses to all these questions included potential use by themselves, now or in the future, and by older adults in general. The frequency of positive and negative responses, along with a brief summary of topic specific comments will be described for each health area question.

Nutrition

Participants were asked about receiving information on healthy eating, accessing a dietician, and annual check-ups of personal nutrition status by their doctor. Table 3 illustrates the distribution of responses. The participant group was split evenly regarding the receipt of information and access to a dietician.

Table 3: Frequency of Responses to Questions Re: Nutrition

Response	*Information*	*Dietician*	*Annual check-ups*
Positive	8	9	15
Negative	10	9	3

All agreed that knowing about healthy eating was important. Of the ten individuals who indicated they did not need information, it was usually because they felt they knew enough about healthy eating or had all the information they needed.

"If I don't know what healthy eating is by now, I never will."

Six of the nine who responded positively to access to a dietician stated that they did not need this now, but it would be helpful if their situation/health changed. For example, if they had a condition such as diabetes, where diet is an integral part of the treatment, or had poor eating habits.

"If I became unsure of myself, if I went to tea and toast, I would definitely need a dietician or nutritionist."

Three of the nine who responded negatively about access to a dietician indicated that they did not need the service, but they could see how it might be helpful to others. The majority of participants were in favour of a regular check-up by their doctor, at which time their nutritional status could be tested. Only ten of these individuals, however, felt it should be annual, and the others felt it should occur regularly but less frequently, or only in response to an identified risk or illness.

"I think that would be a good part of a sort of general physical, general annual physical. I think it would be excellent, to check weight, and as you say, various dietary nutrient levels and things."

Community health clinics

Participants were asked whether they thought community clinics, such as for flu shots, were/would be beneficial to them. Some participants answered specifically in respect to themselves, and some answered in respect to the clinics' usefulness in general. Table 4 illustrates that many participants' interpretation of the question was initially related to receiving flu shots specifically, rather than to the idea of community clinics in general.

Table 4: Frequency of Responses Questions Re: Community Health				
Response	*Use currently for flu shot*	*Flu shot from doctor*	*Currently does not get flu shot*	*In general community clinics are useful*
Positive	5	5	6	18

All the participants felt that community clinics were beneficial, and could serve many purposes. Participants were asked what health issues, in addition to flu shots, they think could be addressed in this manner. Ideas included nutrition, foot care, vaccinations, eye/ear tests, routine medical exams, exercise, and topical clinics such as diabetes, osteoporosis, and memory. Methods of service provision included occasional topical seminars, regular educational workshops, personal care clinics and routine medical services.

"It certainly would be very helpful to be able to go in and just talk to somebody, and either find out that you're on the wrong track completely, or that you need to see a specific person about that."

"Well, I think maybe for just...the exercise component...a few extra clinics or some seminars on what you can...how can you get your exercise on colder windy days or whatever."

Falls

Participants were asked if they would be interested in receiving information related to falls, and what type of information they might want. They were also asked their opinions about annual home visits by a health professional to check their homes for potential risks and hazards. Table 5 illustrates the distribution of responses. Fifteen of the participants answered either positively or negatively to both receiving information, and home visits.

Table 5: Frequency of Responses to Questions Re: Falls		
Response	*Information*	*Home visits*
Positive	15	13
Negative	3	5

The majority of participants were positive to the idea of receiving either general or specific information, related to falls prevention, now or in the future. Two-thirds of the participant group felt that the idea of home visits, now or when needed in the future, was positive. Of this latter group, however, some specified that the visits did not need to occur annually, and that it would be useful as a one-time service, or on an as-needed or requested basis.

> "Oh I think that's excellent...because I think it helps people to be more comfortable and confident in living in their own homes...I think one gets so used to having it in a certain way, and then you don't even see the obvious."

Medications

Participants were asked whether they would be interested in receiving information about their medications, and any interactions between them. They were then asked their opinions about medication monitoring, and annual home visits by doctors or pharmacists, to review their medications. Table 6 illustrates the distribution of responses.

Table 6: Frequency of Responses to Questions Re: Medications

Response	*Information*	*Monitoring of medications*	*Home visits*
Positive	17	15	11
Negative	1	3	7

The majority of participants responded positively to the ideas of receiving information on medications, and having their own medications monitored by their doctor or pharmacist.

> "So I kind of pursue that question whenever I, whenever I get a prescription. You know, how will it affect this medication or that medication, or how will they all interact? And so I think that's really critical information to have."

In fact, many of them indicated that both of these were already occurring. This was stated directly in the interview, or through their descriptions of how their pharmacists provide them with 'printouts' of information pertinent to their new medication at the time

of dispensing. A number of participants wanted and/or were receiving information only on their medications, not medications in general.

Eleven participants supported the concept of a home visit by a doctor or pharmacist to check the medications in their homes and advise on any potential risks. Over half of these individuals felt that this service should be provided only at a time when it was requested, or felt to be necessary.

> "I think again it would be good for somebody whose judgement is of concern, but also for people who take a lot of medications." [Following is an example of this spoken earlier in this participant's interview, involving her own mother] "When we found her, there was one whole group of yellow pills that she didn't know what to do with."

Two other participants also indicated the issue of overmedication of seniors, and that the confusion that occurs when managing multiple medications was a concern.

Driving safety

Participants were asked if they would be interested in receiving information on safe driving. They were then asked how they felt about annual testing, and probed for their opinions regarding set ages, frequency of testing, and what should be included in the testing process. Table 7 illustrates the distribution of responses.

Table 7: Frequency of Responses to Questions Re: Driving Safety

Response	*Information*	*Driving tests*
Positive	16	18
Negative	2	0

Sixteen participants were open to receiving information about safe driving, and many of them were already receiving this type of information, or at least had access to it. Though most were positive about receiving this information, many of the participants were

somewhat ambivalent; it would be fine to receive it, but it was not a great concern to them either way.

"It's not going to hurt"
"Well I sort of get, I'm a member of AMA, I sort of get that information informally. Whether I would access it or not is entirely another matter."

There was unanimous support for regular testing to maintain a driver's license, though there were a variety of opinions regarding the age to initiate testing, the frequency of testing, and the types of activities to be included in the testing process. Five participants indicated that there should be a set age, six thought that age for testing should be individual to each person, and seven were not sure how an 'appropriate' age could be set. Of those who thought that testing should be mandatory at a certain age, all were unsure of what that age should be, and gave possible examples such as 65, 70 and 75.

"So I really think that once you get to a certain age, [driving] should be checked. Age 75 I think would probably be a time to really start, and they could do it each year."

Of the six participants who believed that testing should be based on individual ability and need or in response to a reason, most thought that this indication would come from the person's doctor, or their driving record. For example, whether the individual had been involved in any collisions in the past year, and what were the circumstances surrounding the incident, could indicate need.

"I think the physician needs to be more involved with flagging when that needs to be done."

Only two participants thought that the decision to stop driving or be tested should be initiated by themselves, while the majority agreed with mandatory testing.

"Well I think it should probably be more imposed, because I think self-initiated it probably wouldn't happen soon enough."

Six participants indicated that once it was determined when testing should start, it should occur annually. Six participants did not specify a frequency, and the other six either specified a different frequency, such as 'every couple of years,' or that it should occur as need dictates. Though there was strong support for testing, most participants were hesitant to identify an age that testing should occur and the frequency of the testing.

Most of the participants offered or were probed for their opinions on what should comprise the driver testing process. Six participants thought that the testing should be medically driven only, and that there should be links between the family doctor and the driving authorities so that they could inform them of individuals who may be at risk. No one thought that the test should only include actual driving, and eight participants indicated that there should be both a health-related aspect, and a driving component.

> "I think annual testing, both physical and driver skill and driver knowledge, should be mandatory – do you still have the eyesight and the reflexes, and do you have current knowledge about driving rules and regulations."
>
> "I think you'd have to drive too. I think you could be physically fine in terms of the doctor...but there are a lot of skills that go into driving a vehicle, and I don't think you can rate those until you have actually sat with somebody driving the car."

Three participants stated that the anxiety and stress that would be associated with driving tests would have a great impact on their success with the test.

> "I'm thinking I won't even be able to put the car into gear likely, if there's somebody watching me [laughing]. It would be very stressful for me because I don't react to testing very well. I get, you know, tense."

One participant suggested graduated driving restrictions to certain times of the day, and the use of a simulator to test driving skills instead of an actual driving test.

Proactive health records management system

The participants were asked a variety of questions pertaining to a proposed health records system, in which their health records from all of their health professionals would be kept in a centralized computer records system. The concept initially was left open to interpretation, and then clarification of the system occurred through a discussion between the researcher and the participant. There were two key concepts being addressed through this group of questions: a central, computerized record system, and a review or appraisal process of personal health records. The discussion included questions related to the involvement of their family doctor, or other professionals in reviewing their records to identify health risks or problems, as well as, methods of being contacted about any identified risks or problems. Four areas were coded to enable the frequency counts described in Table 8, and then recurring themes that emerged on this topic will be summarized.

Table 8: Frequency of Response to Questions Re: Proactive Health Records Management System

Response	*First impressions of this system*	*Review of records by their family doctor*	*Review of records by an unrelated health professional*	*Feelings about system-initiated contact*
Positive	12	17	10	17
Negative	6	1	8	1

Upon first glance of the tabulated results above, one can see that two-thirds of participants had a positive impression of the central computerized record system.

> "I think it's inevitable. If the current doctor that you're seeing, consultant that you're seeing, can go to a computer and look that up and say 'oh' this doctor gave you such and such a medication, or he recommended this, did it happen? I think that would be very good for the patient."

Some participants felt that it would be particularly useful if one needed to go to the emergency department, that the doctors there could access their complete file, or if

people were moving from place to place, that they would not have to start their records over each time. Though in agreement with the centralized system, a few participants preferred to have their records in both the centralized system and in their family doctor's office.

"So there has to be a hard copy – they can centralize the database if they want, but I would also want a hard copy in my local doctor's office. Because the advantage of heaving centralized computer system, if I'm taken to the hospital in an emergency, then they can access my file."

The involvement of the family doctor as the professional reviewing these records was seen by 17 of the participants as positive. The involvement of the family doctor, however, also had a major impact on the final column - their opinions regarding system-initiated contact in response to identified health risks or problems. Nine of the seventeen participants, who responded positively to the question about being contacted regarding an identified health issue, qualified their answers; they would feel positive about this contact if it were done by, or filtered through their family doctor.

"Well if that were done [contact], I would like to see it operated some way through my family doctor, so that he would be the first line of contact, and he would be the one that knows me best...I would want to see a filter in the system somewhere."

"I think your family doctor, or any doctor who is looking after you is the only person who should have access to your records...I think it [contact] should go through your family doctor."

Only ten participants responded positively when asked about a professional unknown to them being the one to review their health records.

"...I think there has to be some strict limitations on that. If it's going to be reviewed by somebody else, it has to be someone who has a legitimate interest in your health condition. If I'm going to my diabetic doctor, yes, he should have access. Simply

because I have asked for a consultation with somebody else, they should not have access to it unless I authorize that access."

In addition to the responses described above, six additional areas of comment were made regarding this health records system. They include computer access and stability; the intrusiveness of the contact approach used; personal responsibility & choices; the benefit of a proactive health system; the current system versus the cost of a new system; and the involvement of the family doctor.

The computer aspect of the records system, was a topic of great concern. Ten participants spoke directly about their concerns regarding a computerized system, which fell into two main categories: access to system and personal files, and the stability of the system. Participants were concerned about the security of a computer system, citing examples from the media about 'hackers' getting into very secure systems.

"It would have to be strictly confidential, and then with – in a safe place. I don't know whether that could ever be this, with computers nowadays, it has to be secure."

"A piece of paper in a file, on a file, is not going to be half as easily accessed as computer. You get them breaking into [computer] files all the time aren't they?"

There were also concerns about the breadth of access of health professionals and other 'identified' people such as health insurance companies, and how that was going to be monitored and controlled.

"I think the problem, especially when you're dealing with areas like emotional and mental health, and maybe even spiritual here, that because of certain statements that this could affect employment and so forth if it were released in ways that are not helpful. So there are strengths to it, but great concern."

Three participants found nothing intrusive about any aspect of this system, and ten participants stated that neither the system overall nor the contact aspect in general were intrusive in and of themselves, but that the intrusiveness was in relation to the manner of the approach taken.

"I wouldn't mind [being contacted], but I think it has to be not in an authoritative way, but more everybody working as a team, including yourself."

"But I would want to make sure that they were who they said they were...there's a lot of scams out there, and as you get older, you have to be especially careful so you don't want anyone to say...well maybe it would be better to have a doctor, your doctor, or somebody you know get in touch with you."

Few participants indicated that this system overall would be intrusive, and these concerns were related to the next section, personal responsibility. Four participants felt that these services, if offered, should be at the request of the individual and that they should have control over, or at least be made aware of who is reviewing their records.

"No. Only my own doctor and myself; or a doctor that I authorize to...but not without my authorization...No, I need to approach them. I don't want them intruding on me unless I request....The health system is something for people to use, not to be used by."

Seven participants stated they thought that having potential problems identified early, and then being made aware of them with suggestions for follow up would be helpful and important.

"Well, if there were risks, it would certainly be useful to know what they are...Yeah if the health care system was more proactive in my health care? I'd be okay with that."

"Well, it might be good to know if there was going to be a risk. If somebody phoned me up and said 'I see by these records that this is happening, and that you should...", I think I would actually be quite appreciative."

Six participants, including both those who thought the proposed system was positive, and those who thought it was negative, noted that there were issues related to resources necessary for this system. There were concerns about currently overburdened staff being expected to take on more tasks. Family doctors may not be interested in a large centralized records system, and may not have the time to take on this extra responsibility.

> "Well I think it would be very good. It's putting a lot of responsibility on, time-wise, on those health care workers that would be doing that. I guess I wouldn't want it to be all caught up with a lot of recording and paperwork for the sake of care."

The key to the positive response described above, was the inclusion of the family doctor in all aspects of this system. Some responses that were initially negative became positive when the response was qualified with the involvement of the family doctor. Some participants included their family doctor in all of their responses to these questions. Without this qualifier, there would have been a larger negative reaction to the review and contact aspects of this system.

> "Well if that were done [contact], I would like to see it operated some way through my family doctor, so that he would be the first line of contact, and he would be the one that knows me best…I would want to see a filter in the system somewhere."

Summary

Most participants considered themselves younger than the 'seniors' that would find the more system-initiated services beneficial. More than half of the participants, even if they were not interested in any of these health services themselves, thought the availability of these services to be accessed by those who (and when) they need them, was a positive concept. There was also a feeling that older adults themselves, as well as, society needs to be more "proactive with the well-elderly so they don't become frail". A few participants

mentioned the idea that people should begin to search out the services available and establish good relationship with their doctors, when they were healthy.

Many participants felt that these services should be available not on a regular basis, but as needed or requested, for reasons of both autonomy and cost-effectiveness. Also, service provision should include the family doctor as a contact point or filter of information. The proactive interventions were received well, but were more favoured as services to be accessed, not system-initiated or mandatory.

What sources of health information do older adults use?

The researcher asked the participants a variety of questions regarding their thoughts and opinions about getting information regarding their health or health problems. The questions explored sources the participants currently use to get the health information they require, to delineate whether they used health services for this information. Illustrated in Table 9, are the frequencies of positive responses to the question, "How do you get information regarding your health?"

Table 9: Frequency of Responses to Questions Re: Sources of Health Information

Source of Information	*# of participants*
Contact with my medical doctor	18
Contact with another health professional	14
Contact with the hospital/community health centre/unit	6
Contact with a volunteer/non-profit organization ie. seniors centre	4
Reading reference books/other written materials (ie. Pamphlets)	17
Reading information off the internet	5
Talk to my children or other relatives	10
Talk to my friends	15
Talk to my spouse/partner	11
I don't get information about my health	0
Other - media such as radio, newspapers or magazines	4
Other - other people with similar experiences	2
Other - professional journals and references	1

Similar to the findings previously discussed in this paper regarding use of health care providers, contact with their medical doctor was a unanimous source of information for the participants. Contact with other professionals, reading materials, and talking with friends and family, were the next most common sources of health information.

The follow up to this question was, "Which is your preferred method of getting information about your health and health problems?" Fifteen participants chose their family doctor or other health professionals specific to the issue at hand, either alone or in conjunction with another source of information such as reading, or talking with others.

"Have a nice doctor that you can go to anytime. That I would like."
"From the appropriate professional...well, the ability to talk...one to one is preferred way of getting information."

One-third of the participants preferred reading (paper copy or Internet materials) as their initial source of information, or in conjunction with the 'face-to-face contact' listed above.

"Because I'm a visual person and I retain things. I can hear things and they can...they're gone. But if I've experienced it visually, then I retain it."
"I would prefer if I had some sort of problem to look it up on the Internet and get an idea of what's going on...but if it's come to the crunch like this back that I had, then it's obvious that you go to a doctor. You don't look it up in a book."

What factors influence the use of certain health services by older adults?

The following factors influencing service use emerged throughout the latter phases of analysis. Each factor will be described within the context of the study, and in relation to the participants' personal experiences, as well as, to their perceptions based on the experiences of others. These broad factors and the indicators identified within each were perceived by this sample as influencing their use of 'health services'.

Need

The factor of need was the overarching influence on service utilization. This factor included the perceptions of the participants regarding when they felt they needed to seek health services. The other factors that will be discussed were put forward by participants with the understanding that there already was a 'need'. There were two main indicators of need: need due to the severity or duration of illness/injury, and the need for regular check-ups to maintain health.

"I only go when I'm quite concerned or in for a check-up periodically".

Need due to severity or duration was queried directly by the researcher, as one of many potential factors that may influence use of services, but also emerged throughout other questions in every interview. The need for regular check-ups also emerged throughout the interviews, for example, when questioned about the use of traditional health services. This factor was based almost solely on personal experiences.

The severity or duration of illness directly determined the participants' seeking assistance from a health professional or tending to a health problem themselves. Types of problems tended to by themselves included issues the participants had experience with, was familiar with, or felt that they can handle it, such as a cold or small injury, and were considered routine or normal ailments, and were tended to as such. Participants described the point at which they sought assistance in various ways.

"...if something really bugs"
"...persisted for awhile"
"I had to get something attended to because I couldn't function"
"...if I had a cold that lasted weeks and weeks and weeks"
"...if I feel there's something I can't handle, I'm to the doctor"

When asked about how often they see their health professionals, one-third of the participants stated regular check-ups with their doctors, dentists, and eye doctors were an important part of maintaining their health. This comprised another aspect of 'need'.

"Yes. I have an annual general medical check-up once a year, automatic."

The researcher queried the participants about various elements that may affect their decisions to use health services, such as beliefs and past experiences. Though a bad experience may have an influence on the use of a particular professional or service, participants were firm across the questions, that they utilized services when they needed them, not, for example, just because they were available. The following excerpt illustrates a dialogue commonly found across the interviews.

Researcher: "You've said the services are excellent. Would that affect you using them more or less at all?"
Participant: "I would only use them when I really needed them...It doesn't, one way or the other."

Relationships with health professionals

This factor included the various interactions with health professionals that may positively or negatively influence the use of certain health services. It was comprised of three indicators: relationships with their family doctors, attitudes of health professionals, and the participants' ability to understand the health professional.

The role of the family doctor in their interactions with the health system was only queried directly, regarding the proactive health records management system. The importance of the family doctor as a link in their health care was apparent throughout each interview and across participants. For example, ten participants stated interactions with their

family doctors in their responses to the question regarding positive experiences with health professionals in the past twelve months, and two others mentioned that all of 'their' professionals were good. Comments included:

"reassuring and relaxing...felt he could go back if the problem persisted"
"known for years, very up front, calls a spade a spade"
"GP is completely present with her"

The involvement of their family doctor in the review of records and contacting individuals regarding risks was prevalent throughout the questions on the proactive health records management system. Several of the positive responses to these hypothetical situations described were actually dependent on the inclusion and active participation of their family doctor.

"Yes I would think that [review] was alright, as long as they then relayed that information to your family doctor...or to your family health care person."
"...if that was a task that was assigned to that person *by* your family doctor, and if that person reported *to* your family doctor then I wouldn't have any problem with that"

Though both positive and negative attitudes of health professionals were mentioned in this study, negative perceptions were particularly prevalent. Descriptions of supportive attitudes were commonly associated with discussions about family doctors. The negative comments were associated with condescending or authoritarian attitudes, and often related to a concept of 'time'.

"I think it would be wonderful if the doctor had time to call me [laughs] and actually talk on the phone, or at least ask me to come in for an appointment. That'd be a real switch."

These emerged as a desire for a health professional to spend more time with them, experiences where this was not the case, or feelings that they are 'bugging' the doctor, wasting his/her time. A few participants mentioned that they felt that there is an attitude by some in society, including health professionals, that seniors are dispensable, and not important.

> "I know professionally they're well-trained, but sometimes in their approach to senior people, particularly with some major disabilities, and *particularly* when they are institutionalized – I've seen this more than once – that they really tend to write these people off."

Though understanding the doctor and the health information being given emerged as an indicator for relationships with health professionals, it played a less significant role than the two other indicators. A few participants commented that there could be a lack of understanding due to patients' sensory deficits such as hearing loss, which made it more difficult to hear already difficult explanations. Issues of language barriers or lack of understanding of medical explanations were also said to impact on the degree of understanding of the health information being relayed. These issues might cause them to seek another professional, whom they could better understand.

> "...an awful lot of us don't hear everything and if you miss one word, you maybe miss the whole concept. And you don't know what you don't know."

A participant suggested that clarity of an explanation could be improved through the use of multiple communication methods, such as explanations, drawings, and pictures to describe the problem and what could be done to address it.

Feelings of personal control

This factor contained statements related to the desire to have some control over what was happening in one's life, in the area of health and health decisions. The indicators included staying independent in the community, initiating access to services, and making the decisions and choices regarding their health. Independence and personal control were not queried directly in the interview, but emanated strongly throughout most. One-third of the participants commented on the importance of remaining independent and not being 'told' what to do, to older adults.

> "...be as independent as you can for as long as you can, and I don't care what you do...I think that is as much a mental issue as a physical issue....Let commonsense prevail in what you do, but don't give up."

This factor was particularly apparent in the questions on system-initiated proactive health interventions. In the five health areas mentioned in the section on proactive health interventions, feelings of personal control emerged chiefly in the questions about home visits to check for risks for falls or to review medications, and in mandatory driver testing. Of the two-thirds of the sample that felt that home visits relating to falls prevention was a good service to have, many of them felt that it should be provided upon request or when needed, instead of annually. This pattern was repeated for home visits for medication reviews.

> "I think that would be useful if it was available sort of on request. If there's an elder person or elderly couple that are concerned, it would be nice if they could have somebody to come in and sort or make that assessment"
>
> "To me it'd be intrusive. If I phoned and wanted the service, by all means, it should be available, but not automatic."

Though driver testing was unanimously felt to be needed, most of the participants were unsure of how to set mandatory guidelines, or thought it should be based on the individual. They wanted the person to have as much involvement as possible in these decisions.

> "I'd be willing to give up driving when I know that...I feel that I'm a good driver and...but if there comes time if I thought that I wasn't, then I would give up driving, eventually yes, if I had to."

This desire for personal control also emerged in the questions regarding a proactive health records management system. Thirteen participants had opinions about the system that pertained to personal control and independence. These comments were related to the confidentiality of the computerized health records, authorizing access to these records, maintaining the right to make the final decision regarding risks once identified, and the review of their records being initiated by themselves instead of by the system.

> "I think again you know, as an individual, you'd maintain the right to say I'm prepared to take those risks or not take them."
>
> "I guess it would be good if *I* initiated it, and asked him [doctor] to do that....As long as I was feeling mentally and physically capable to make decisions and live on my own, that I would be the one that should initiate those kinds of reviews"

Availability of services

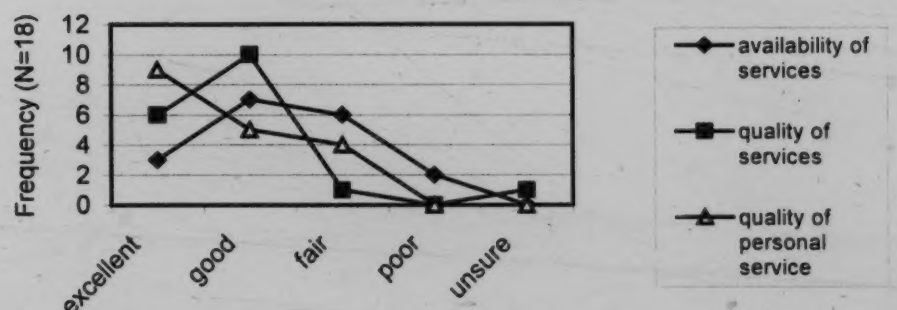
This factor contained opinions and experiences related to the ability to access services when needed. It consisted of three key indicators: the cost of services, the location of services, and the waiting time to access services. Availability of services was queried directly in the interviews; as well, the interview data were coded in their entirety for indicators encompassed within availability of services. Participants were asked to

consider the health care system overall when rating the availability of health care services for people their age in their community from excellent to poor. Figure 4 illustrates the frequency of this rating. Ten participants rated the availability of services as 'good' or 'excellent', and two individuals rated them as poor.

When cost was referred to in the interviews, it was related to the actual cost of services, the cost of, and lack of money in the health system, and of the limited financial means of seniors relative to the first two. Some participants were upset with the transfer of service costs from the public system to themselves. Cost was said to not only influence when and how often a necessary service is used, but whether it was accessed at all. Cost only negatively impacted a few participants personally. Most comments were based on the perceptions of others' experiences.

"...I think for some, the cost is prohibitive...[relating experience with physiotherapy] ...the cost is really quite high, and the coverage isn't that great...and I think in the senior years, often there is a need for more, because your body doesn't heal as easily or as quickly...many people might stop, that after the paid visits are over, but the problem still continues and so actually, they don't get the complete health benefit"

Figure 4 : Availability & Quality of Health Services



Key responses regarding the location of services were framed in an urban – rural discussion. Participants noted that the availability they experienced was good, but they did not perceive that to be the case in smaller rural settings.

"I think the big cities like...I think you're gonna get your best services, which is unfortunate in a way because you're closer. The good ones don't want to go out of town."

The majority of positive responses in the previous two areas were based on personal experience, and the concerns, on perceptions of others' experiences. Positive and negative responses on waiting time for health services were much more evenly split. Many of the participants had not experienced waiting lists firsthand, but either knew of or had read about someone who had. Some who had experienced them, though frustrated by it, considered the waiting as part of using services in this health care system. Only a few had not been able to get the service when they needed it, due to waiting lists.

"But certainly given that there are waiting periods, I certainly...I received quite good health care."

"Well, certainly it wasn't available at the time required because there was a waiting list...and the cost of going privately would have been too much for the type of procedure it was...they're only available if you're an inpatient"

Quality of services

This final factor encompassed the participants' perceptions of the quality of health services that were currently being provided. Quality of services was queried directly in the interviews; as well, the interview data were coded in their entirety for indicators encompassed within quality of services. This factor included indicators of quality of the overall health system, as well as, quality of individual services.

Participants were asked to consider the health care system overall when rating the quality of health care services for people their age in their community, and their personal experiences when asked to rate the quality of any health care they had received within the past twelve months. The rating scale again ranged from excellent to poor, and the frequency of responses to both questions can be seen in Figure 4. Sixteen participants rated the quality of services as 'good' or 'excellent', and 14 rated the quality of their own personal experiences the same way. Comments on quality also emerged throughout each interview.

> "I think the ones [older adults] I've talked to feel that the health care system is pretty good. Some are a little frustrated that some expenses have been transferred from the public system to them, but generally they have positive things to say about the quality of health care within the system."

Though one participant commented negatively on the current staffing quality of the health care system, this was an atypical case for this sample. The majority of comments related to overall quality were positive. Over one-third of the participants shared their opinions on the health care system overall, comparing it to other systems, and to private health care.

> "I feel very strongly that we have a very fine health care system except for the overwork. I believe that nurses are overworked, and I think sometimes, the doctors too, and other professionals. But as far as services, I just look at that and I see tremendous offerings and choice and possibilities, and at a low cost to us."
>
> "...there's nothing you can do to convince me that things are fine in health, and yet I know that when we look at provinces around this country...this is by far the best province to live in."

The perception of quality became an influencing factor especially for certain types of services. For example, if participants perceived that alternative service providers were

not of the same quality as traditional ones, this may influence their use of these services, whether potentially beneficial to them or not. This may also occur after a bad experience with a health professional, whether personal or relayed by another individual.

> "I generally shied away from alternative medicines because I think they're [pause] they're kind of unproven quantities in our culture."

Even if there were concerns with the availability, often there were no issues with the quality. For example, two participant rated the availability of services in general as 'fair', and then the quality as 'excellent', stating there were no problems with the health care workers and the service once you could get in.

Member checking

Four participants - three women and one man, each age group being represented - were contacted to meet again to discuss the findings. These particular participants were not contacted because of particular comments that they had made in the interviews, but as the first ones contacted for each age group, ensuring both genders were represented. The researcher wanted to get their feedback on their findings for each research question, to get a sense of whether they felt the findings were an accurate portrayal. All of them were enthusiastic about the findings and felt that they were thorough. They agreed with the multiple components of perceived health. One person said that though this multiplicity made sense, she personally thought only of physical health, when questioned in the interview.

Most thought that in a larger study, family involvement may be seen as a component, though no family or social supports were mentioned in this study as a component of perceived health. There was some surprise with the low frequency of use of services,

and it was believed that if this study was done with an older group, that an increased use of services would be seen. They also agreed with the proactive nature of use that was found in the study.

The major factors influencing the use of services were all supported, and especially that 'need' drove services. Two of these participants were concerned with the importance placed on the family doctor, stating that health was much more than the aspects a family doctor can address. All agreed, however, that older adults did place importance on the involvement of their family doctor, but also agreed that further exploration was needed on this topic.

They stated that it was difficult to think of one's personal situation in terms of being a 'senior'. They all thought that is would be interesting to see a larger study comparing these topics and the variables within, across ages, socioeconomic status, and social support networks. As well, some thought studies focused on more homogeneous groups, to examine more closely the experience of those in that particular situation, such as low income older women, would be interesting.

CHAPTER V:

DISCUSSION

Introduction

This small qualitative study used a semi-structured interview method to collect data to answer three main research questions - How do older adults perceive their health status? What health services do and would older adults use? What factors influence older adults' use of certain health services? This method allowed participants to answer questions with as much detail as they desired. Following is the discussion of what was found in this study, to answer these research questions. "Negotiating the Healthy Self" is a theoretical model exploring the health behaviours of older adults (White, 1996). This model will be used in addition to the reviewed literature, to further discuss the findings of the study. First, however, is a brief look at the sample chosen for the study.

Sample

This sample was a convenience sample, obtained through a snowball sampling technique. The sample was comprised of the young-old, those 60-75 years of age, and had a good distribution across this age group and gender. Most were in fairly good health, and many were not requiring extensive use of services at this time. They all had opinions, however, on the questions being asked regarding their health and the provision of health services. Cultural background was not determined through questioning, but this was not an ethnically diverse sample. Though lacking in diversity and small in size, this researcher felt that the sample was adequate for a first step in exploring health perceptions and use of health services, with the goal of improving understanding and contributing to health service planning.

How do older adults perceive their health status?

This study found that for this small sample aged 60-75:

1. they perceived themselves as being quite healthy,
2. their perceptions of health were multidimensional in that various components comprised their descriptions of their health ratings, and
3. that activity/energy levels, physical health, frequency of illness, attitudes, and independence were the most prominent components addressed in their perceptions.

When compared to the literature and theoretical model, many similarities were found, thus adding support to past literature, but for a younger sample of older adults than often seen before in research.

1. Though similar in pattern to the findings for those age 65-74 in the 1996/97 NPHS (FPTACPH, 1999), this study had a slightly higher percentage of individuals rating their health as excellent or very good. Most other studies have also found that older adults often rate themselves as healthy (Borawski et al., 1996; Dening et al., 1998; Hudson & Leventhal, 1999; Menec et al., 1999). This study showed no pattern of poorer health ratings with increasing age, as the age range was quite narrow and it was a fairly young sample.

2. Like other studies (Borawski et al., 1996; Idler et al., 1999; Kaufman, 1996; White, 1996), this study explored the make up of these perceptions with the participants themselves. It showed that the participants' perceptions of health status were comprised of the following components: activity/energy levels; physical health/impact of health problems; frequency of illness/visits to doctor; attitude; independence; comparison to others; changes to lifestyle; and spirituality. As in the literature, the components touched

on physical, psychological and social areas, with the predominant components varying for each study. Similar to Borawski et al. and Idler et al., this study included comments of both a positive and negative nature.

The model by White (1996) found that older adults constructed a definition of their own 'healthy self' based on personally relevant and peer-referenced components. Similar to the current study, she found that older adults incorporated aspects of their physical appearance and ability, physical & mental activity levels, social interactions and roles, and social comparisons with others, into their definitions of themselves as a 'healthy' person.

3. The most prevalent components comprising this sample's perceptions of health addressed activity/energy levels, physical health and illness, attitudes, and independence. These were also four key areas addressed in the literature on components of perceived health.

As in Kaufman's study (1996), activity level was pervasive as a component of their perceived health status. Though less prevalent, Idler et al. (1999) addressed activity/energy levels within 'health-related behavior' and 'social role activities', and Borawski et al. (1996) in their 'behavioral' component. Hall et al. (1989) explored this area but found no association. Though this and other components have been illustrated across studies, physical health and illness remained prominent in these perceptions of health.

Three of the studies, Borawski et al. (1996), Hall (1989), and Idler et al. (1999) found 'physical health focussed', 'physical health/diagnoses/symptoms', and 'physiological status', respectively, to be the predominant components of perceived health in their studies. Kaufman's 'basic function' and 'absence of medical conditions' (1996), and this study's 'physical health/impact of health problems' and 'frequency of illness/visits to doctor' components, though not the dominant components, were quite prevalent nonetheless.

Supported in the literature (Hall et al., 1989; Idler et al., 1999; Kaufman, 1996), 'physical health and the impact of health problems' did contribute to the participants' perceptions of their health status, even though their health ratings were very positive. These results add support for the pattern of positive health ratings despite the presence of health problems (Borawski et al., 1996; Dening, 1998; Idler et al., 1999). This perceived and objective health 'contradiction' may not be a contradiction at all, but merely an illustration of the multidimensionality of the ratings of perceived health.

In her grounded theory study on the health behaviours of older adults, White found that chronic health problems the participants believed to be age-related and/or not modifiable were incorporated into their self-definitions (1996). This model may provide an explanation to help us understand the apparent contradiction above. Older adults may not perceive certain health problems as impacting on their lifestyle, but as simply being part of it. Another possible explanation is in relation to the multiple components of perceptions of health. As health problems comprise only one or two components of this perception, their impact may be much less than when physical health is the only

component considered. Borawski et al. (1996) found that 'health optimists' focussed on attributes other than physical health as well.

Attitude as a component of perceived health was supported in all studies, and its strong presence in this study was supported across most. Kaufman had a component labeled 'attitude' (1996), and Idler et al. found it to be a strong aspect of their component labeled 'psychological, spiritual, emotional' (1999). Borawski et al. (1996) found it to be the dominant aspect of their 'attitudinal/behavioral' component, but Hall et al (1989), found it to have much less significance compared with the more physical components.

Feelings of independence (including mobility) as a component of perceived health was found in one-third of the participants' perceptions. It was seen as a strong component in Idler et al. (1999) within their category of 'physical functioning'. Borawski et al. (1996) and Hall et al. (1989) found 'functional capacities' and 'functional status' respectively, which addressed functional independence, to be present within their participants' perceptions. Kaufman (1996) found independence addressed only in a very small way, within their 'activity' component.

Components that were less prevalent in this current study were also seen in the literature, and often were also the lesser prevalent components in each study. Comments made about a changed lifestyle or as a comparison to others their age that were used to describe their perceptions of health, played a less significant role in perceptions of health in this study. Borawski et al. (1996), Idler et al. (1999) found only minimal support for changes to lifestyle as a component of perceived health. They also found comparisons to others within their perceptions of health labeled 'externally

focussed' and 'social relationships' respectively, and these had a greater presence than comments related to lifestyle. Kaufman (1996) found comparisons to others in only 5 of 78 statements made overall, captured within 'attitude'. Spirituality, which was mentioned by a couple of participants in this study, was a relatively strong aspect of the 'psychological, spiritual, emotional' component in Idler et al. (1999), but a fairly weak aspect of the 'externally focussed' component in Borawski et al. (1996).

The findings in this study confirmed and supported findings in the literature that illustrate this multidimensionality. The other studies had either older participants or a broader age range than this study, but there were still many similarities in the nature of the components. This overlap of findings between studies suggests that similar components of perceived health might be found with other older adults. Though there are similar components, perceived health was still very individual as seen in this study. Each participant emphasized different things in their health rating descriptions, and considered a number of aspects of their lives within their perceptions of health. What cannot be determined, however, is the inclusion of components by age or gender as this sample is much too small to determine such patterns.

Older adults in this study perceived themselves as being fairly healthy, despite having some health problems. The multiple components of perceived health found in this study, suggest that older adults may consider things such as their activity and energy levels, the impact of health problems, and their attitude in their perception of health. These are therefore areas to address and incorporate in health program and service planning for older adults. Kaufman (1996) agreed, stating that older adults would then find the programs more relevant and meaningful.

What health services do and would older adults use?

The following key findings describe the use of health services by this sample:

1. traditional and alternative services were both used minimally and according to need,
2. there was a positive response to the availability of proactive interventions on request, but mandatory driver testing was also supported,
3. a proactive records management system overall was responded to positively, but dependent on the involvement of their family doctor, and
4. speculative questions have limited use in determining future service use.

When actual services used were compared to the literature for a parallel age group, many similarities were found, adding support to this literature. However, when compared overall to the literature for older adults, key differences were seen in the area of driver testing, and the strong desire for the involvement of the family doctor. This was also a younger sample of older adults than often seen before in similar research.

1. Traditional & alternative health care providers

This sample's use of traditional health care providers is similar to that found in the literature, in that the greatest use was for doctors, and then dentists and eye specialists (Statistics Canada, 1997). Their overall rate of use was less than expected from some of the statistics on service utilization; however, those statistics often encompass all adults over age 65. This pattern of use was likely due to the fact that this sample is comprised of quite healthy, young-old adults, and matched the findings of Rosenberg & Moore (1997), that those aged 65-74 had patterns of use similar to adults younger than themselves rather than older. Much of the use was related to maintaining their health as well as responding to illness, which has also been seen in past surveys (FPTACPH, 1999).

The high frequency of regular check-ups mentioned as part of their use of services suggests a proactive approach to maintaining health. This was also found in the 1996/97 NPHS, as over half the participants had a physical and eye exam in the last year, and just less than half had a dental exam within this period (FPTACPH). This is significant as these older adults are moving toward an age group typified by increased service use, and may want services to incorporate this proactive approach. Very few participants had used alternative health care providers in the recent past, as found in the 1996/97 NPHS (FPTACPH, 1999). Need was again instrumental in the potential use of these services, as it was mentioned that in times of serious illness one might try anything.

This sample tended to use and currently favour the more traditional types of services. The recommendations of their family doctor also figured prominently in their decisions to use either type of services. The pattern of use for both traditional and alternative health services found in this study suggests that maintaining their health and responding to problems effectively was their priority, and that 'need' drove their use of these services.

2. Proactive health interventions

Those who were positive about receiving information on one topic usually were positive across the health areas. Many of those who were negative about receiving information about nutrition and falls, became positive about receiving information about medications and driving safety, health areas that seemed to perceived as more serious by the participants. Though the question on community health resulted in various interpretations of what 'community health' meant, and therefore difficult to analyze, it was apparent that having access to services in their local community was a good idea. Again, the responses indicated that community health clinics would be a good place for health promoting and educational activities.

Falls and medications were seen as two important areas for older adults, and that service provision in these areas, for people who needed them, was important. Fox et al. (1997) also found that health promotion programs addressing these topics were received well. Various studies found proactive health interventions beneficial for older adults (Breslow et al., 1998; Fox et al., 1997; Hay et al., 1998). The 1996/97 NPHS found a large percentage of those 65-74 used various proactive interventions such as screenings, check-ups, and vaccines regularly (FPTACPH, 1999).

Another pattern was that many wanted the services to be available upon request, not mandatory. Support for this can be drawn from the findings in Musil et al. (1998) and Stoller et al. (1997). Both studies found that older adults used self-care for some things and health professionals for others, but the decision was theirs to make. The participants stated that services were used only when needed, whether to respond to illness or proactively maintain one's health. The patterns of use found for this group indicates a much more proactive and necessary use of services than illustrated in the media and some of the literature focused on those over age 65.

The unanimous support for driving tests for people as they age was surprising, as this seemed like it would be an intrusive topic and one that threatens independence. There was great uncertainty about how and when it should occur, but the participants were quite open to discussing it. The uncertainty may indicate that people are wary of setting some hard and fast rules about driving tests, but the strong support for testing infers that people also understand the importance of it.

> "It [not driving anymore] does take away your independence, but there comes a time when you have to be big enough to see that your independence could affect other people's lives, not just yours."

This finding of strong support for testing is opposite of most research done in the area of mandatory driver testing in older age. Other research has found that older adults are not in support of being tested to be able to maintain their license, strictly because they had reached a certain age. This current study's findings on driver testing could be related to the young age of the sample, and the idea that some services would be good for 'others' and those older than themselves. They may not have considered that this would directly affect them because they did not perceive themselves as seniors or elderly, or that they personally would be at risk of losing their license.

3. Proactive health records management system

The strong positive response to the proactive health records management system was also a surprise, as the researcher believed that the perceived intrusiveness of this system, compared with the current way of doing things, would evoke a stronger negative response. This system was supported, however, through the adaptations and conditions that participants applied to the proposed computerized records system and system-review process.

This study proposed a system that used information from health records to identify risks. Of the studies reviewed in the literature, two were mail surveys (Breslow et al., 1997; McCusker et al., 1999) and the other was initiated in-person with the older adults (Dalby et al., 1999), but all were self-report. The concerns with access to records without their knowledge or authorization, therefore, was not at issue in these studies. Much of the discussion in this study was about feelings of control over the decisions regarding who could review their records, and what their responses to the identified risk would be. This latter concern was addressed by Breslow et al. in that once an HRA-E form had been

assessed and the risk report completed and sent back, it was up to the individual whether to follow the recommendations in the report.

Similar to this study's participants' strong desire for the involvement of their family doctor in the review of their records, Dalby et al. (1999) believed that their strong response rate was due to the enclosure of a letter from each participant's family doctor with the survey. The health risk appraisal developed by Breslow et al. (1997) was similar to the one proposed in this study in that it was targeted population wide, whereas the other two were targeted to those older adults already known to be somewhat at risk. As this focus on the opinions of older adults toward such a system of risk identification had not really been addressed in the literature before, these findings can be a beginning point in exploring older adults' responses to the implementation of such a risk identification system.

4. Speculative questions

Many themes emerged throughout the section on proactive health interventions, and the discussions on a proactive health records management system. The findings related to future use, however, should be interpreted with great caution because of their speculative nature. The reliability of speculative responses regarding future service use is usually less than that for past or present reporting of use (Shi, 1997). Some participants also found it difficult to answer questions about hypothetical future use of health services. Hypothetical questions have been found in other studies such as Thompson (1986) to be difficult for participants to answer. A pattern found across the questions regarding the proactive health interventions was that when participants did not feel that they needed the service, they often said that they thought it would be helpful to

others. Most of the participants, however, felt that they were too young to need services such as home visits. This pattern may also explain their strong support for driver testing. This theme of 'them not me' adds support to the researcher's caution about the participants' speculated future use of services. The participants may not have considered that they will ever become 'them', which could have lead to some of the unexpected findings.

For the proactive records management system the caveat must also be included, that even though these findings were not based on speculations of future use at a time when one might be more vulnerable, it still required the participants to speculate on an intangible concept currently not in place. They must be interpreted as such.

What sources of health information do older adults use?

Many of the participants used multiple sources for information about their health or health problems. In White's study (1996), she also found that health information often came through print media, interactions with others, and with health professionals. Face to face contact with their family doctor to talk about an issue was the predominant preference as a source of information in this study. People wanted to be able to trust that the information they are getting is accurate, and that the source they are getting it from has their best interests at heart. This describes most accurately the usual relationship with a family doctor.

What factors influence older adults' use of certain health services?

The key factors influencing service use that emerged in this study were:

1. factors included need, relationships with health professionals, feelings of personal control, availability of services and quality of services,
2. need was the predominant underlying factor influencing service use, and
3. the involvement of the family doctor was very important.

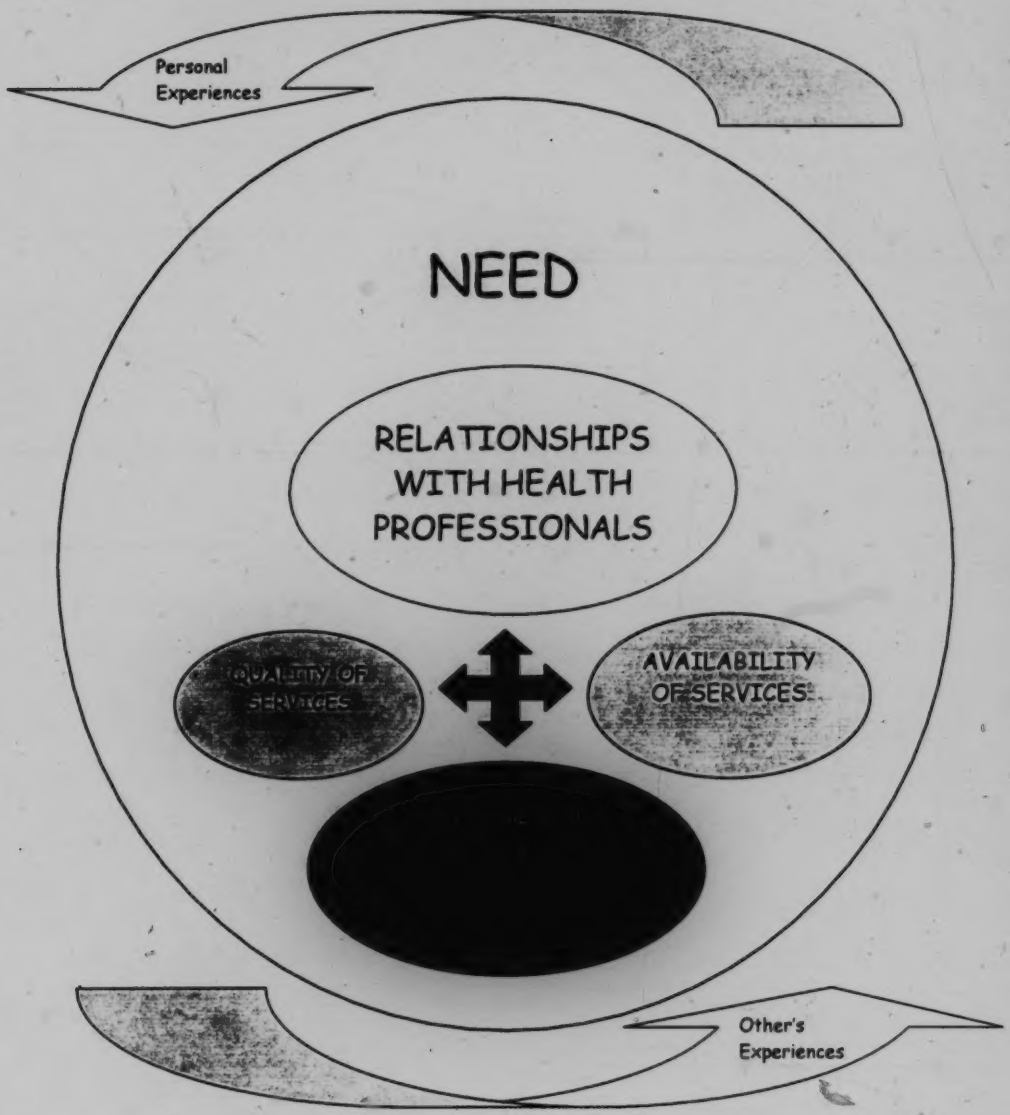
The factors found in this study are illustrated in Figure 5, as is their relative impact, as interpreted by the researcher for this study by the intra-participant and inter-participant repetition of the topics. That these factors are supported in the literature suggests that they may be similar for other older adults.

1. All of the factors found in this study were seen in the literature, and therefore add support to the past research. Need – due to severity/duration of illness - was determined by the impact it had on their daily lives and normal activities, or the 'effect on function'. Dill et al. also found that for symptoms considered 'common' no assistance was sought (1995). Other studies provided support for this finding, as they found that properties and severity of symptoms (Stoller, 1998), perceived severity of illnesses (Berman & Iris, 1998), and both actual symptoms and perceived severity (Kart & Engler, 1995) may affect the course of action taken, and whether to seek health care assistance.

In the current study, need was inclusive of the proactive aspect of needing to maintain one's health by regular check-ups. Hurwicz's study was the only one in the literature that found something similar. He found that a group of participants only used the doctor

for routine treatments, and that they went regularly; therefore, one may interpret this regularity as a need to maintain their health (1995).

Figure 5: Factors Influencing Use of Health Services



The role of relationships with a family doctor as an influence for service use was also seen in studies on the doctor-patient relationship (Padula, 1992), the linking of satisfaction with services with the interpersonal relationship (Owens & Batchelor, 1996), and on long-term relationships between patients and doctors (Haug, 1996). These studies, however, focused mostly on communication between patient and doctor, and the current study found the involvement of the family doctor as distinctly separate from the indicator addressing communication.

Attitudes of health professionals impacting on the use of services was seen in a study looking at ageism in health services (Adelman et al., 1991), which supported the negative responses found in the study. Similar to the findings in this study, other studies have found that doctors either did not take the time to talk, or made older patients feel like they were bothering the doctor (Koval & Dobie, 1996; Lee & Kasper, 1998). One of the results of these attitudes delineated by some participants was that they would put off going to the doctor as long as possible.

The final indicator within 'relationships with health professionals', understanding the health professional, was also strongly supported in the literature on communication. Physical limitations such as hearing loss, and characteristics of the doctor or patient such as gender or language, were found in this study and the literature to affect communication, and therefore understanding (Adelman et al., 1991; Bene et al., 1998). Many of these topics can be linked with the importance of building a relationship with a family doctor, and having that person involved collaboratively with health and health service use decisions.

The concepts of personal responsibility, self-initiated services, and making decisions on service choices appeared across the participant group and across topics, forming the factor of 'feelings of personal control'. The influence of autonomy or personal control on service use was also seen in some of the studies on self-care, which found that whether individuals chose to tend to symptoms themselves or seek assistance, they made the choice (Dill et al., 1995; Musil et al., 1998; Stoller et al., 1997). Berman & Iris found three approaches to care in their study. Two of these, 'doing and thinking for yourself' and 'doing very little at all', both involved taking control of one's health care and health (1998). Two other studies highlighted the importance of the involvement of older adults in their health care decisions, and recommended strategies to facilitate this (Davies et al., 1997; McWilliam et al., 1997).

In White's model (1996) health behaviours were considered to be the responsibility of the individual, so the decisions made regarding whether to use services to promote their health or respond to a threat were up to the individual. Owens and Batchelor, however, found that many of their older participants felt that the doctor should make all decisions regarding use of services (1996). Their finding appears somewhat atypical, and was likely related to the fact that their sample included frailer adults requiring regular nursing services. Only a couple of participants in the current study felt that the 'imposed' approach to services would be all right, and the rest wanted some control over these decisions. This factor was about being actively involved, and taking the lead in decisions affecting one's own health. Most of the services discussed in the study were met with positive responses, but usually if the person had control over the decision to use them.

Availability of services was shown in the literature as impacting on health service choices. Cost and location issues were seen as influences on the use of services in this study and others (Koval & Dobie, 1996; Linda Macleod & Associates, 1997; Whetstone & Reid, 1997), though this study's findings were almost strictly based on the participants' knowledge of others' experiences not their own. Waiting lists have had great attention in the media, but these participants considered waiting personally as an influencing factor usually on when, not if they would receive the services needed.

The perception of quality of services overall was very positive. The perception of quality became an influencing factor especially for certain types of services, due to both positive and negative beliefs about quality, or experiences with certain services. Similarly found by Owens & Batchelor, the interpersonal relationship between doctor and patient, whether positive or negative, plays a major role in the satisfaction of the patient (1996). The faith in their quality of care would decrease, and therefore that person would likely not use that service or health professional. If not satisfied with their care, patients were more likely to delay seeking help in the future (Bene et al., 1998).

The 'selective health promotion' and 'managing threats' aspects of White's model (1996) involved the appraisal of a body cue or health information to determine its threat or merit, to determine the action to be taken. This appraisal process considered factors including severity, familiarity, perceived control, available treatment, and previous health care response (White). These are similar to aspects of all five of the factors identified in this study, as influences on decisions to use services.

All of the factors likely interact and impact on each other. This would be especially true for 'need', as it underlay all of the other factors for this sample. Relationships with health professionals, for example, may interact with need, when utilization of services in response to need is delayed because of the anticipation of a negative interaction with the health professional. The factors' interactions would also likely be greatly dependent on and vary according to individual situations. The interaction among the factors was not explored in this study; therefore, further discussion would be to extrapolate beyond the findings. This could be an area of further research.

2. Using services based on their determination of 'need' was predominant throughout the study, which has not been strongly illustrated before in the literature. One must be cautious with this comparison, since some of studies did not examine multiple factors for the same group of people. Nevertheless, need emerged as a major factor influencing the use of health services. The other influencing factors were important, but came into play after 'need' had been established.

3. The inclusion and active involvement of a family doctor in the various health services discussed in this study, was evident in most participants, and was a finding not strongly evident in the literature. Though the importance attached to the involvement of the family doctor was not seen in the literature directly, it was supported indirectly through studies on the doctor-patient relationship (Padula, 1992), and on long-term relationships between patients and doctors (Haug, 1996). Haug found that these long-term relationships can be both beneficial and detrimental to the older patient, but the majority of participants in this study, who discussed their relationship with their family doctor, mentioned benefits only. This could be in part because the findings were based solely on

the perceptions of these older adults, who may not have considered drawbacks to the long-term nature of their relationship with their doctor if it had been positive overall.

The five key factors that emerged throughout this study as having an influencing effect on the use of certain health services were fairly straightforward – need, relationships with health professionals, feelings of personal control, the availability of services, and the quality of services. Their relative impact was only briefly discussed, and their interaction with each is not known from this study; neither was directly measured. These factors were supported by the literature as having an influence, but the predominance of need as an influencing factor on the use of services did not appear as strongly in the literature. The strong desire for the involvement of the family doctor in the health services older adults receive had also not been delineated before in the literature, and was particularly strong in the acceptance of a health risk identification system. Areas such as social support and culture, which were seen in the literature as factors influencing health service use, did not emerge as factors here, though the influence of cultural beliefs and family were both queried directly in the interviews.

Summary

There have been some key things learned from the process and findings of this study. Participants rated their health very positively, and included activity/energy levels and attitude as key components in their perceptions of health, in addition the physical health focussed components. The older adults in the sample used health services in a comparable way to younger rather than older age groups, which indicates that to explore potential service use by those considered the 'old-old', they are the ones that need to be studied. These participants took a fairly proactive approach to their health, and to

decisions on when services were used. A system of risk identification overall was perceived positively, but the involvement of the family doctor was deemed necessary by most participants.

This study has shown that to determine the use of services for when people are older, speculative questions should not be used. Current use of services by a sample of adults older than those in the current study would be needed. These speculative questions also lead to a phenomenon of 'them not me' which also limited the ability to use this data to predict future service use. Participants used 'need' to guide their use of services, and preferred to take an active role in their health decisions, in conjunction with a trusted family doctor.

Implications of the results

The results from this study could have implications for various people providing health-related services. This study portrayed the older adults who participated accurately, with multidimensional perceptions of health, fairly good health, use of services according to need, and the desire to participate actively in their health service choices.

As perceived health has been shown to include components such as activity levels and independence, doctors should question older patients about these aspects of their lives, as well as, their physical health when evaluating the health of these patients. Doctors need to understand what aspects of their patients' life, that they incorporate into their perceived health, may be negatively or positively impacting on their health. The relationship between doctor and patient and the communication between them has been shown in this study to be aspects of a prominent factor influencing the use of health

services. Doctors must check with their older patients to ensure they understand the medical explanations being given to them regarding health and health problems.

There are also implications for health planners who will participate in the future planning of health services for older adults. Some literature has shown that health programs that incorporate aspects of older adults' perceptions of health increase their acceptance and success. In addition to physical health, the importance of 'activity and energy levels' as a component of older adults' perceived health has been shown in this study. Health planners need to now explore why and how it impacts on older adults' perceptions of health, and what potential barriers to maintaining their activities and their energy levels need to be addressed. They can then determine what if any of these results can be addressed through health planning. The desire for the involvement of the family doctor in the participants' use of health services was strongest when responding to questions regarding the proactive records management system to review health records and identify risks. When developing any similar type of proactive risk identification system, family doctors must be included in its structure and processes for it to be a successful and accepted service by older adults.

Strengths of the study

This study provided an opportunity for exploration into the ratings of perceived health status and the influencing factors on service use for these young-old adults. It also went beyond service utilization patterns to explore the reasons, beliefs, and opinions behind the patterns. Data was all audio-taped and transcribed, so the data directly reflected the opinions and thoughts of the older adults in the sample. Copies of the questions were offered to the participants at the beginning of the interview so that they could follow

along, and use it to clarify questions. This idea was met positively by the participants, and was a good way to keep the process transparent. This study's findings provided a solid starting point upon which future research in this area could build, and some tangible results that could be used by health professionals and health planners.

Delimitations & limitations of the study

The findings were based strictly on those older adults participating in the study and could not necessarily be generalized to other older adults. The single method of data collection chosen somewhat limited the information obtained. The study did not look at variables such as ethnic background, socio-economic status, or social support. Information that may illustrate patterns associated with these types of variables was therefore not available.

Participants were only interviewed once, so the questions about future use could only be speculated, which has minimal usefulness for planners without further verification of actual use of these services. These speculative questions also seemed to create a 'them not me' response that was difficult to interpret. Given that the results addressing use of services were more similar in pattern of use to younger adults than older, and that much of the use of proactive interventions had to be speculated, the age group chosen for the sample was too young to provide strong results in this area.

Recommendations for future research

A study using a larger sample would enable more generalizeabilty to the population as a whole, and one could explore if there were differences across demographic variables such as age, culture, gender and socio-economic status that may be important to consider in health planning. Multi-method approaches should be utilized in future

research to provide avenues for triangulation of the findings. Revisiting participants more than once would provide some verification of their responses over time, and would encourage a deeper reflection on the research topics being explored.

Both the components of perceived health and the factors influencing service use could be used to frame further research exploring the prevalence and influence of each component/factor across a larger sample of individuals. If future health service planning is to be based on the research evidence, there needs to be replications of similar studies, to provide results that are representative of the majority of older adults. Next steps for this research could include studies further exploring the components within the perceptions of health, and the factors influencing service use. The findings of this study for use of health services indicate that current use, not speculated future use needs to be explored with an older age group than used in this study. In addition, a longitudinal study examining the correlation between speculated and actual use of services would add to the research on the utility of hypothetical questioning.

CHAPTER VI:

CONCLUSION

The population in all societies is aging, and the percentage of our population that is over the age of sixty-five is growing steadily. With this continued increase in the older adult population, and as the baby boomers are fast approaching this point in their lives, health service planning for older adults has become more of a priority, to ensure that services are in place to meet the growing needs. A first step in health services planning for older adults was to find out directly from older adults how they perceived their health status, and what influenced their use of certain health services. That was the purpose of this study.

There had been numerous research studies which statistically looked at the self-rating of perceived health, and perhaps in correlation to other variables. It has become a common measure of the health of an individual or population. What needed further explored was the meaning behind the rating, to the individuals themselves. Though there has been research done on the components contained within each rating, it had been with samples over the age of 70 or inclusive of a broad age range. There were also statistics kept on service utilization for groups differentiated by age, income, or other variables. Again, however, the details behind the use of services, such as the factors that influence this use, were minimal for young-old adults. These types of data could be used to enrich the patterns of service utilization data, and provide important information on the underlying factors for this utilization.

This study used a qualitative approach with a small sample of 18 older adults between the ages of 60 and 75, to explore the concepts of perceptions of health, health services use, and the factors that may influence this use. This group was relatively understudied in research, and as they are considered the young-old, may have increased use of health services in the near future. Semi-structured interviews were chosen to collect the data, as they allowed for respondents to answer questions in as much detail as they would like, while maintaining consistency with the questions being asked. On average the interviews lasted 45 - 60 minutes, and no issues arose related to the research process itself.

This group of participants considered themselves quite healthy. In describing why they used a certain rating for their health, a number of types of descriptions were used, which included many different aspects of their lives. A list of components of perceived health was derived from these descriptions, which included eight key topics that were repeated across participants. These components were similar in nature to those found in other studies. In addition to physical health focussed components, both activity/energy levels and attitude placed prominently in the perceptions of health.

The participants in this sample leaned toward using more traditional types of services, though based most service decisions on their need for those services. A strong proactive approach to their health emanated throughout the study, especially regarding regular check-ups with their key health care providers, and in their positive responses to proactive interventions discussed in the interviews. They felt that though these services were beneficial and useful, that they should be used when needed, not as a mandatory or a regularly system-initiated service. As the patterns of service use found for this

sample indicated their use was similar to younger adults, an older sample would need to be identified to explore service use patterns for older adults. It was preferred that health information be obtained through their family doctor solely, or in conjunction with other sources such as the Internet.

Due to their perceived intrusiveness, two somewhat surprising findings, within this section were (1) the unanimous support for mandatory driving testing for older adults, and (2) the strong favourable response to the computerized health records management system, and records review process. The finding on driver testing was unique to the literature on this topic, and could have been partly the result of the limitations of speculative questions. Both of these findings did come with many caveats and conditions, but the general concepts were strongly supported.

Some of the speculative findings on future use of services, however, needed to be viewed with caution, as there is minimal predictive reliability with these types of questions. These speculative questions also seemed to create a phenomenon of 'them not me' which adds to the caution of their interpretation, as this group of participants overall did not perceive themselves as people who would need these services.

There were five factors found to influence service use: need, relationship with health professionals, feelings of personal control, availability of services and quality of services. The main factor influencing the use of health services was that of 'need', as determined through severity or duration of illness, or the necessity of check-ups in maintaining one's health. When questioned about other potential factors that could influence their choice of certain services, most participants made it clear that though these other factors have

some influence, the bottom line for them using services was whether they need to use them or not.

'Relationships with health professionals' included their relationship with their family doctor, the attitudes of health professionals, and their understanding of what health professionals say. The importance of the family doctor within their preferences for service provision was clear and pervasive. An example of this was through the inclusion of the family doctor in a system used to identify health risks. 'Feelings of personal control' was a factor that also clearly emanated as an important consideration for these participants. Independence and services that supported that independence were priorities for this group.

The last two factors, 'availability of services' and 'quality of services' played a less dominant role in influencing service use than one might have imagined. Though identified in the literature as important influences on service use overall, they were not strong influences for this group of individuals. Most of the discussion for these factors was borne out of examples and experiences of other older adults that they knew, or through stories in the media.

The findings from this study could have many implications in various settings. Health professionals should use the knowledge of the predominant components of older patients' perceptions of their health to address a more holistic health status of their patients. Those involved with planning and developing future health services for older adults should explore into the impact of 'activity and energy levels' as a component of

health, and include the family doctor as a contact point in any health risk identification system.

The key findings from this study each need to be explored further with samples that are older than this sample. As well, in a larger study the interaction of these concepts with other variables, such as demographics, will be important information to attain. This continuing research will provide a solid research evidence base upon which health services planning decisions can be made.

In this time of limited resources and perceived increased service use by an older population, the findings from this study are promising, and should not only be an initial step for continued research in this area, but considered and addressed in health services planning and implementation.

References

Adelman, R.D., Greene, M.G. & Charon, R. (1991). Issues in physician-elderly patient interaction. Ageing and Society, 11, 127-148.

Appleton, J.V. (1995). Analysing qualitative interview data: Addressing issues of validity and reliability. Journal of Advanced Nursing, 22, 993-997.

Bene, J., Liston, R. Nelson, L., Devine, M.J., Banerjee, A.K. (1998). Elderly patients' satisfaction with hospital care. Journal of the Royal College of Physicians of London, 32(2), 138-141.

Berman, R.L.H., & Iris, M.A. (1998). Approaches to self-care in later life. Qualitative Health Research, 8(2), 224-236.

Bernard, H.R. (1995). Research methods in anthropology - Qualitative and quantitative approaches (2nd ed.). California: Sage Publications.

Borawski, E.A., Kinney, J.M., & Kahana, E. (1996). The meaning of older adults' health appraisals: Congruence with health status and determinant of mortality. Journal of Gerontology: Social Sciences, 51B(3), S157-S170.

Breslow, L., Beck, J.C., Morgenstern, H., Fielding, J.E., Moore, A.A., Carmel, M., Higa, J. (1997). Development of a health risk appraisal for the elderly (HRA-E). American Journal of Health Promotion, 11(5), 337-43.

Capital Health. (1997). How healthy are we? Health status in the Capital Health Region: A technical report 1997. Edmonton, AB: Capital Health.

Creswell, J.W. (1998). Qualitative inquiry and research design: Choosing among five traditions. California: Sage Publications.

Dalby, D.M., Sellors, J.W., Fraser, F.D., Fraser, C., van Ineveld, C.H.M., Pickard, L.., & Howard, M. (1999). Screening seniors for risk of functional decline: Results of a survey in family practice. Canadian Journal of Public Health, 90 (2), 133-137.

Davies, S., Laker, S., & Ellis, L. (1997). Promoting autonomy and independence for older people within nursing practice: A literature review. Journal of Advanced Nursing, 26, 408-417.

Dean, K. (1989). Self-care components of lifestyles: The importance of gender, attitudes and the social situation. Social Science & Medicine, 29(2), 137-154.

Dening, T.R., Chi, L., Brayne, C., Huppert, F.A., Paykel, E.S., O'Connor, D.W. (1998). Changes in self-rated health, disability and contact with services in a very elderly cohort: A 6-year follow –up study. Age and Ageing, 27, 23-33.

Dill, A., Brown, P., Ciambrone, D., & Rakowski, W. (1995). The meaning and practice of self-care by older adults: A qualitative assessment. Research on Aging, 17(1), 8-41.

Federal/Provincial/Territorial Advisory Committee on Population Health. (1999). Statistical report on the health of Canadians. Ottawa: Minister of Public Works and Government Services Canada.

Federal/Provincial/Territorial Ministers Responsible for Seniors. (1998). National Framework on Aging Policy Guide. Ottawa: Minister of Public Works and Government Services Canada.

Fontana, A., & Frey, J.H. (1994). Interviewing - The art of science. In N.K.Denzin & Y.S. Lincoln (Eds.), Handbook of qualitative research (pp.465-78). California: Sage Publications.

Fox, P.J., Breuer, W. & Wright, J.A. (1997). Effects of a health promotion program on sustaining health behaviors in older adults. American Journal of Preventive Medicine, 13(4), 257-264.

Hall, J.A., Epstein, A.M., & NcNeil, B.J. (1989). Multidimensionality of health status in an elderly population. Medical Care, 27(3 supplement), S168-S177.

Haug, M.R. (1996). The effects of physician/elder patient characteristics on health communication. Health Communication, 8(3), 249-262.

Hay, W.I., van Ineveld, C., Browne, G., Roberts, J., Bell, B., Mills, M., Chambers, L, Gafni, A., Macpherson, S. (1998). Prospective care of elderly patients in family practice: Is screening effective? Canadian Family Physician, 44, 2677-2687.

Higgins, I. (1998). Reflections on conducting qualitative research with elderly people. Qualitative Health Research, 8(6), 858-866.

Hurwicz, M. (1995). Physician's norms and health care decisions of elderly Medicare recipients. Medical Anthropology Quarterly, 9(2), 211-235.

Idler, E.L., Hudson, S.V., & Leventhal, H. (1999). The meanings of self-ratings of health: A quantitative and qualitative approach. Research on Aging, 21(3), 458-476.

Kart, C.S., & Engler, C.A. (1995). Self-health care among the elderly: A test of the health-behavior model. Research on Aging, 17(4), 434-458.

Kaufman, J.E. (1996). Personal definitions of health among elderly people: A link to effective health promotion. Family & Community Health, 19(2), 58-68.

Kavanaugh, K. & Ayres, L. (1998). "Not as bad as it could have been": Assessing and mitigating harm during research interviews on sensitive topics. Research in Nursing and Health, 21, 91-97.

Kayser-Jones, J. & Koenig, B.A. (1994). Ethical issues. In J.F.Gubrium & A. Sankar (Eds.), Qualitative methods in aging research. California: Sage Publications.

Konrad, T.R. (1998). The patterns of self-care among older adults in western industrialized societies. In M.G. Ory & G.H. DeFriese (Eds.), Self-care in later life: research, program, and policy issues. New York: Springer Publishing Co.

Koval, M. & Dobie, S. (1996). Why do the elderly seek or avoid care? A qualitative analysis. Family Medicine, 28(5), 352-357.

Lee, Y. & Kasper, J.D. (1998). Assessment of medical care by elderly people: General satisfaction and physician quality. Health Services Research, 32(6), 741-757.

Linda Macleod & Associates. (1997). Toward healthy-aging communities: A population health approach. Ottawa: Division of Aging and Seniors.

Marshall, C. & Rossman, G.B.(1995). Designing qualitative research (2nd ed). California: Sage Publications.

McCusker, J., Bellavance, F., Cardin, S., Trepanier, S., Verdon, J., & Ardman, O. (1999). Detection of older people at increased risk of adverse health outcomes after an emegency visit: The ISAR screening tool. Journal of the American Geriatrics Society, 47, 1229-1237.

McWilliam, C.L., Stewart, M., Brown, J.B., McNair, S., Desai, K., Patterson, M.L., Del Maestro, N., & Pittman, B.J. (1997). Creating empowering meaning: An interactive process of promoting health with chronically ill older Canadians. Health Promotion International, 12(2), 111-123.

Menec, V.H., Chipperfield, J.G., & Perry, R.P. (1999). Self-perceptions of health: A prospective analysis of mortality, control, and health. Journal of Gerontology: Psychological Sciences, 54B (2), P85-P93.

Miles, M.B., & Huberman, A..M. (1994). Qualitative data analysis: An expanded sourcebook, 2nd edition. California: Sage Publications.

Morse, J.M. & Field, P.A. (1995). Qualitative research methods for health professionals (2nd ed). California: Sage Publications.

Musil, C.M., Ahn, S., Haug, M., Warner, C., Morris, D. & Duffy, E. (1998). Health problems and health actions among community-dwelling older adults: Results of a health diary study. Applied Nursing Research, 11(3), 138-147.

Owens, O.J. & Batchelor, C. (1996). Patient satisfaction and the elderly. Social Science & Medicine, 42(11), 1483-1491.

Padula, C.A. (1992). Self-care and the elderly: Review and implications. Public Health Nursing, 9(1), 22-28.

Pett, M.A. (1997). Nonparametric statistics for health care research: Statistics for small samples and unusual distributions. California: Sage Publications.

Rodger, B.L. & Cowles, K.V. (1993). The qualitative research audit trail: A complex collection of documentation. Research in Nursing & Health, 16, 219-226.

Rosenberg, M.W., & Moore, E.G. (1997). The health of Canada's elderly population: Current status and future implications. Canadian Medical Association Journal, 157, 1025-1032.

Rothe, J.P. (1994). Qualitative research: A practical guide. Ontario: RCI/PDE Publications.

Sefton, J. & Mummery, W.K. (1995). The well-being of seniors in Alberta: An Alberta perspective on the national survey on ageing and independence. Edmonton: Alberta Centre for Well-being.

Seidman, I. (1998). Interviewing as qualitative research: A guide for researchers in education and the social sciences, 2nd ed. New York: Teachers College Press.

Shi, L. (1997). Health services research methods. New York: Delmar Publishers Inc.

Statisics Canada . (1997). National Population Health Survey 1996-97 Household Component Questionnaire. Ottawa: Statistics Canada: Health Statistics Division.

Statistics Canada. (1997). A portrait of seniors in Canada (2nd ed.) (Cat.No. 89-519-XPE). Ottawa: Minister of Industry.

Stoller, E.P. (1998). Dynamics and processes of self-care in old age. In M.G. Ory & G.H. DeFriese (Eds.), Self-care in later life: research, program, and policy issues. New York: Springer Publishing Co.

Stoller, E.P., Kart, C.S., & Portugal, S.S. (1997). Explaining pathways of care taken by elderly people: An analysis of responses to illness symptoms. Sociological Focus, 30(2), 147-165.

Thompson, M.S. (1986). Willingness to pay and accept risks to cure chronic disease. American Journal of Public Health, 76(4), 392-396.

Ulysse, P. (1997). Population aging: An overview of the past thirty years. Ottawa: Health Canada - Division of Aging and Seniors.

Whetstone, W.R., & Reid, J.C. (1991). Health promotion of older adults: Perceived barriers. Journal of Advanced Nursing, 16, 1343-1349.

White, B.S. (1996). Negotiating the healthy self: A theory of health behavior in older adults. Michigan: UMI Dissertation Services.

APPENDICES

Appendix A

Health Research Ethics Approval

Note: The title for the project has been changed since the ethics approval of the study. The previous title was, "How Do Older Adults Maintain Their Health?

Health Research Ethics Board biomedical research health research

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UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES, CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date:	August 1999
Name(s) of Principal Investigator(s):	Ms. Patricia Leggett
Organization(s):	University of Alberta
Department:	Graduate Studies; Department of Public Health Sciences
Project Title:	How Do Older Adults Maintain Their Health?

The Health Research Ethics Board has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the patient information material and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval.

Sharon Warren

Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

File number: B-050799-PHS

Appendix B

Example Poster for Sample Recruitment

What do you think about health care in Alberta?

Would you like to share your thoughts on health and health services for older adults?

We want to know:

- what kinds of health services you use;
- what affects your decision to use services; and
- how you feel about various health services in Alberta.

We hope the results of this study will do the following for older Albertans:

- improve experiences with health professionals, &
- help with the planning of future health services.

If you are 60-75 years old, and interested in more information on participating in this study, please call any time until December 10th, 1999.

Patricia Leggett Ph.# 436-6544

Graduate student, Dept. of Public Health Sciences, University of Alberta

Appendix C

Information Letter

Title of Project:

**Perceptions of Health & Use of Health Services:
An Exploratory Study with Older Adults**

Principal Investigator:

Patricia Leggett MSc student 436-6544
Department of Public Health Sciences

Co-Investigators:

Dr. Lory Laing Professor 492-8282
Department of Public Health Sciences
Dr. Peter Rothe Assistant Professor 492-7066
Department of Public Health Sciences
Dr. Norah Keating Professor 492-4191
Department of Human Ecology

September 1, 1999

Dear Participant,

The purpose of this study is to understand what it means to older adults to be healthy. Also we want to understand what influences their decisions to use health services. Finally, we want to explore how older adults feel about various health services aimed at maintaining their health. The objective of the study is to use the experiences of older adults to increase our understanding of older adults' health decisions. This research study is a graduate thesis project.

Participation in the study

There will be about twenty to thirty people interviewed in total for the study. The interviews will occur in a place comfortable for you, and suitable for a private discussion. There will be an initial meeting to discuss the study and the consent form. There will be a second meeting for the interview, lasting about 1-1/2 to 2 hours. You may be contacted for a follow up meeting to discuss findings from the study. The interviews will be scheduled between mid-September and the end of November 1999, at your convenience.

Confidentiality and voluntary participation

The interviews will be recorded on audio cassette tapes. All interview records are kept private and only the investigators will have access to the information. Names will be removed from all information, and no names or other identifying information will be used in any reports or presentations. After the study is complete, the primary investigator will store all the information in a locked storage cabinet for at least 7 years. If additional analysis is to be conducted with the study data, further ethics approval will be required.

You can choose to answer or not answer any of the questions during the interview. You can choose to stop the interview or withdraw from the study at any time. All information will be held confidential except when professional codes of ethics and/or legislation require reporting.

Benefits and risks

There are no direct benefits for individual participants. The results should increase our understanding of older adults' decisions and perceptions of health. There are no risks directly associated with participation in this study. If you feel the process itself is becoming difficult, it can be adjusted or stopped. For example, if you become tired or ill during the interview. General information regarding services available to older adults will be brought to the interview, which you can keep if you want it.

More information

For further information or questions about the study, please call:

Patricia Leggett @ 436-6544 Dr. Lory Laing @ 492-8282

If you have any concerns about any aspect of this study, you may contact the Patient Concerns Office of the Capital Health Authority at 407-1040. This office has no affiliation with study investigators.

Appendix D

Research Study Consent Form

Title of Project:

Perceptions of Health & Use of Health Services:
An Exploratory Study with Older Adults

Principal Investigator:

Patricia Leggett	Public Health Sciences	436-6544

Co-Investigators: Include affiliations and phone number:

1. Dr. Lory Laing	Public Health Sciences	492-8282
2. Dr. Peter Rothe	Public Health Sciences	492-7066
3. Dr. Norah Keating	Human Ecology	492-4191

Do you understand that you have been asked to be in a research study? Yes No

Have you read and received a copy of the attached Information Letter? Yes No

Do you understand the benefits and risks involved in taking part in this research study? Yes No

Have you had an opportunity to ask questions and discuss this study? Yes No

Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your current or future health or medical services. Yes No

Has the issue of confidentiality been explained to you? Yes No

Do you understand who will have access to your interview records? Yes No

Do you understand that participation in this study will not directly affect, either positively or negatively, your current or future access to health or medical services? Yes No

Do you understand that the interview will be recorded on an audio cassette tape, to be used for the analysis part of the study? Yes No

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____
Signature of Research Participant Date Witness

_____ _____
Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee Date

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE STUDY PARTICIPANT.

Appendix E

Example of Interview Guide

I am going to be asking you a variety of questions related to your health, what you do to look after your health, and who you see about your health. Please let me know when you want a break, or want to stop completely. You can stop any time, and you can choose to not answer any question or questions that you do not want to answer. Do you have any questions before we start? ..... OK let's begin.

1) A. In general, would you say your health is:

____excellent ____very good ____good ____fair ____poor

B. What things do you think of to describe your health as _____?

2) A. I am going to go through a list of health professionals, please tell me if, in the past 12 months, have you seen or talked to any of the following people regarding your physical, emotional, or mental health?

B. If yes, how often?

C. If you needed health care, which others would you use?

	A	B	C
a) Family doctor or general practitioner			
b) Eye doctor or specialist (such as an ophthalmologist)			
c) Other medical doctor (ie. Surgeon, allergist, gynaecologist or psychiatrist) - please specify the type(s) of specialist_____			
d) A nurse for care or advice			
e) Dentist, denturist or orthodontist			
f) Chiropractor			
g) Physiotherapist			
h) Social worker or counselor			
i) Psychologist			
j) Speech, audiology or occupational therapist			
k) Other _____			

Comments

3) A. People may also use alternative or complementary medicine. In the past 12 months, have you seen or talked to any of the following alternative health care providers about your physical, emotional or mental health?

B. If yes, how often?
C. If you needed health care, which others would you use?

	A	B	C
1 Massage therapist			
2 Acupuncturist			
3 Homeopath or Naturopath			
4 Relaxation therapist			
5 Herbalist			
6 Reflexologist			
7 Other (specify)			

4) What health problems do you tend to yourself?

- Probes: examples - colds & flu, injury

5) The next questions are related to things that might influence your decision to go to the doctor or other health professional.

a. How does severity of a health problem affect your decision to go?

b. During the past 12 months, was there ever a time when you felt that you needed health care but you didn't receive it? If yes, what was the situation?

c. What is the most common reason you don't get health care when you need it?

Probes:	
1 It was not available in the area	
2 It was not available at time required (ie. Doctor on holidays, inconvenient hrs)	
3 The waiting time was too long	
4 I felt it would be inadequate	
5 The cost would be too much	
6 I was too busy	
7 I didn't get around to it or didn't bother	
8 I didn't know where to go	
9 I had a transportation problem	
10 I had a language problem	
11 I had personal or family responsibilities	
12 I dislike doctors/ I am afraid of doctors	
13 I decided not to seek care	
14 I had other reasons (specify)	

d) Do you have any cultural, religious or other beliefs that might affect your decisions to use certain services?

6) Thinking now about the health care system overall:

a) how would you rate the *availability* of health care services for people your age in your community?

1 Excellent
2 Good
3 Fair
4 Poor

b) how would you rate the *quality* of health care services for people your age in your community?

1 Excellent
2 Good
3 Fair
4 Poor

c) how would you rate the quality of any health care *you* received in the past 12 months?

1 Excellent
2 Good
3 Fair
4 Poor
5 Didn't receive any health care services

d) Does the above quality and availability of services affect your decision to use the services? How?

7) A. Can you describe a positive experience you have had with a health professional in the last 12 months?

B. Can you describe a negative experience you have had with a health professional in the last 12 months?

➢ Probe: positive/negative interactions; quality & type of information; attitudes; support

8) How do these past experiences affect your feelings about health services, and your use of them?

Reminder about their right to stop or not answer any question they don't wish to

9) A. How do you get information regarding your health?

1 Contact with my medical doctor	
2 Contact with another health professional	
3 Contact with the hospital/community health centre/unit	
4 Contact with a volunteer/non-profit organization ie. seniors centre	
5 Reading reference books/other written materials (ie. Pamphlets)	
6 Reading information off the internet	
7 Talk to my children or other relatives	
8 Talk to my friends	
9 Talk to my spouse/partner	
10 I don't get information about my health	
11 Other (Specify)	

B. Which is your preferred method of getting information about your health and health problems? – why?

10) Some older adults have said that they want more information about their health and how to look after it. Following are some different ideas about possible ways to get better information. I would like to hear your opinions on how you want the health care system involved in the following areas, both for what you want now and what you might want in the future.

a. Nutrition – Do you/would you want to receive information (pamphlets etc.) on healthy eating?

Do you/would you want to be able to access a dietician to help you plan your meals?

How do you feel about an annual check up of your nutritional status by your family doctor? (ie. Nutrient levels in your body, weight, etc.)

b. Community health - Do you/would you think that community clinics such as for flu shots, are beneficial to you?

Are there other health issues you would like to see addressed in this way?

c. Falls - Do you/would you like to receive information on falls prevention? What kind?

How do you feel about an annual home visit from a health professional (ie. nurse) to check your home for risks and provide suggestions to you?

d. Medications – Do you/would you want to receive information about all the medications you use, and how they affect each other?

Do you/would you like your doctor or pharmacist to monitor what you use, both prescribed and over the counter medications?

How do you feel about an annual home visit from a health professional (ie. pharmacist) to check the medications you have in your home and advise you on any problems?

e. Driving safety – Do you/would you want to receive information, for example pamphlets, on how to check your driving safety?

How do you feel about annual testing to determine whether your driving should be limited?

11) This question is about how involved you want the health care system in looking after your health. The information from your doctor and hospital visits is kept in your health records. This is often now kept on a computer.

a) How do you feel about having all the information from your visits with all health care professionals kept on one records system?

b) What if information from these records was reviewed regularly (ie. 2X/year) by your family doctor to identify your risks for certain health problems (ie. risk for falls injuries):

- by another health professional within the health care system

c) How do you feel about then being contacted by someone in the health system about these risks, with suggestions for looking after them? How do you feel about the health system approaching you in this way regarding your health instead of you approaching it?

Probes for #11 (Would this type of system seem helpful to you? Would you be comfortable with it, or does it feel intrusive?)

12) You have answered many questions about your health and the health care system. Now I would like to ask a few questions to get some background information. Please share only in as much detail as you feel comfortable.

- What is your date of birth?

- Who lives in your household?

- Are you still working? What was/is your main job or occupation?

  - If not, are you: Retired_____ unemployed_____

  - By choice_____ due to illness/disability of self or others_____Other_____

  - Comments:

13) Have you been diagnosed with any of the following by a health professional:

	Yes	No
A. osteoporosis		
B. Memory problems		
C. Arthritis or rheumatism		
D. Hearing problem		
E. Back problems, excluding arthritis		
F. High blood pressure		
G. Migraine headaches		
H Chronic bronchitis or emphysema/lung condition		
I. Depression or anxiety		
J. Diabetes		
K. vision problem such as Cataracts or glaucoma		
L. Heart disease		
M. Cancer		
N. Stroke and its effects		
O. Urinary incontinence		
P. Alzheimer's disease or any other dementia		
Q. Any other long-term condition that has been diagnosed by a health professional:		
Additional comments:		

14) Is there anything you would like to tell people working in the health care system about health and health care for older adults?

15) Do you have anything else you would like to share, about health services for older adults in Alberta?

Thank you for sharing your thoughts and experiences with me.

Appendix F

Intercoder Reliability

Kappa Statistic for Inter-coder Reliability – Coder #1

Researcher * CODER 1

Crosstab

Count

		CODER 1										Total
		CC-LTC	FAC-B&A	FAC-BAR	FAC-EXP	FAC-FAM	FAC-SEV	HI	HM-MED	HM-NU	PER	
Researcher	CC-LTC	1										1
	FAC-B&A		1									1
	FAC-BAR			1								1
	FAC-EXP				1							1
	FAC-FAM					1						1
	FAC-SEV						1					1
	HI							1				1
	HM-MED								1			1
	HM-NU									1		1
	PER										1	1
Total		1	1	1	1	1	1	1	1	1	1	10

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	9.487	.000
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Kappa Statistic for Inter-coder Reliability – Coder #2

Researcher * CODER 2

Crosstab

Count

		CODER 2										Total
		CC-LTC	FAC-B&A	FAC-BAR	FAC-EXP	FAC-FAM	FAC-SEV	HI	HM-MED	HM-NU	PER	
Researcher	CC-LTC	1										1
	FAC-B&A		1									1
	FAC-BAR			1								1
	FAC-EXP				1							1
	FAC-FAM					1						1
	FAC-SEV						1					1
	HI							1				1
	HM-MED								1			1
	HM-NU									1		1
	PER										1	1
Total		1	1	1	1	1	1	1	1	1	1	10

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Measure of Agreement	Kappa	1.000	.000	9.487	.000
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.